STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005714	A. BUILDING: _____ B. WING _____	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN LONG GROVE REHAB &HC CTR	2308 OLD HICKS ROAD LONG GROVE, IL 60047

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S 000	Initial Comments Complaint Investigation #1911639/IL110149	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.3100d)2) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b)The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6)All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.	S9999	**Attachment A** **Statement of Licensure Violations**	

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Section 300.3100 General Building Requirements

d) Doors and Windows
2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met evidenced by:

Based on observation, interview, and record review the facility failed to ensure the door alarm was activated and failed to supervise a resident who was high risk for elopement. These failures resulted in R1 exiting the facility unknown to staff at 4:30 AM March 7, 2019. R1's whereabouts were not known for an hour and ten minutes.

R1 left the facility unknown to staff and was discovered walking 2 miles from the grounds near a busy intersection, and had fallen, and hit his head.

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This applies to 1 of 4 residents (R1) reviewed for safety/supervision in the sample of 5.

The findings include:

R1's March 2019 Physician's Order Sheet (POS) shows R1 was admitted to the facility on September 11, 2018 and has diagnoses that include Psychotic Disorder, with hallucinations due to known physiological condition, Huntington's disease. R1's January 2, 2019 Minimum Data Set (MDS) shows that R1 is cognitively impaired, requires assistance with mobility and is not steady with walking. R1's MDS also shows he requires assistance with activities of daily living (ADL's). R1's active care plan dated through April 2, 2019 shows that he is high risk for falls, has deficits with ADL's, requires staff assistance when walking, and is high risk for elopement. Interventions show 1:1 immediately upon attempt, and every 15-minute checks following. The care plan goal indicated the resident will remain safely on the unit or under supervision. R1's March 2, 2019 Elopement Risk Assessment shows that he is high risk for elopement. R1's March 6, 2019 Elopement Risk Assessment completed at 11:00 AM shows that R1 was discontinued from 1:1 even though he had continued verbalizations as recently as 3/4/19 about wanting to leave the facility.

R1's February 28, 2019 nursing progress notes shows that R1 became upset and began yelling and demanding to go home with his family and pushed his mother out of the way to go through the front door. R1's March 1, 2019 nursing progress note shows at 5:00 PM R1 was still verbalizing a desire to go home and walked through the front door of the facility. R1's March 4, 2019 nursing progress note shows at 6:02 PM

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R1 was still verbalizing a desire to go home and R1 stated "I want to go home and get out, I goanna walk." R1's March 6, 2019 nursing progress note shows at 11:00 AM R1's 1:1 monitoring was discontinued, and he was started on 15-minute checks. R1's March 7, 2019 nursing progress note shows at 4:40 AM another resident from the facility (R2), informed V6, Licensed Practical Nurse (LPN) that R1 had went outside. (R1) was unable to be located and the police were notified. The same note states the police found him and brought him back to facility. At 6:15 AM R1 was sent to a local community hospital for evaluation.

A local police department report shows, "On March 7, 2019 at approximately 5:10 AM {5 deputies} were dispatched to {the facility} about a missing adult male. {dispatch} advised that facility staff reported a patient, (R1) had walked away from the facility at approximately 4:30 A.M. Staff advised that (R1) has Huntington's disease, and a psychotic disorder with hallucinations. (R1) was last seen wearing a black jacket, and blue jeans. Upon arriving, I spoke to the facility administrator (V1) via telephone. (V1) said she checked the surveillance cameras remotely but didn't have footage of (R1) leaving the facility. (V1) said her staff checked the interior of the facility but were unable to locate (R1). She said (V6) was caring for (R1) before he went missing. I then spoke to (V6). He said and not verbatim that he last saw (R1) in his room at 4:00 A.M. He said at approximately 4:30 A.M. another patient told him he saw (R1) leave the facility through the main doors. (V6) said normally the main doors are alarmed but someone must have deactivated the alarm because he did not hear the alarm go off. (V6) said once they determined (R1) was missing the facility began checking the interior, and

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exterior of the building. He said the staff were unable to locate (R1) so they called the police. While I was speaking to (V6) another staff member said someone called and reported a male walking north on {a busy street approximately 2 miles away}. I then requested one of the Deputies check this area. A short time later {the Deputy} said he located (R1) {walking on a busy intersection}. {The Deputy} brought (R1) back to the facility. "Additional narrative states. "On 03-08-19 {Sgt.} was reviewing reports and read {the deputies} report titled Missing Adult. In summary, (R1) ... "left the facility at about 4:30 AM and was located a few miles aware on {a busy street} at about 5:40 AM {an hour and ten minutes after exiting the facility}. Due to (R1) being exposed to the cold elements, (R1) was transported to the hospital." ...

R1's March 7, 2019 Emergency Room (E.R) records from a local community hospital show R1 arrived via ambulance at 6:28 AM. R1's 6:28 AM E.R. progress note states "Patient reported he escaped from the facility at {4:30 AM} and was found wandering down the streets a few miles from the {facility}." Additional notes said that R1 reported he had fallen backwards and hit his head while he was out walking on the street attempting to walk home.

On March 8, 2019 at 4:45 PM, R2 said he was sitting in the front lobby overnight playing on his new phone the night of March 7, 2018 into the morning hours. R2 said that at 12:30 AM he saw V5, Certified Nursing Assistant (CNA), open the main door to let another resident (R6) into the building, and shut off the door alarm without turning it back on. R2 said that at approximately 3:30 AM he himself let the laboratory girl into the building, he did not see staff present at that time

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and the alarm definitely did not sound because it was not on. R2 stated "I saw another resident (R1) walk out the front door at 4:30 AM the alarm was not set, or it would have gone off." R2 said at 4:40 AM when he found the nurse (V6) he notified him that R1 had left out the front door. On March 11, 2019 at 10:15 AM, R2 said that the door alarm was usually turned on and off by a keypad on the door and that the staff frequently turn the alarm off at night. R2 said that V1 (Administrator), V2 (Director of Nursing), and V3 (Assistant Director of Nursing) have all come to talk to him about witnessing R1 leaving the facility that morning. R2 said he told them all about witnessing V5 turn the alarm off at 12:30 AM. R2 said that when the day shift came in that morning the alarm was working. R2 said that V6 turned the alarm on when the police came to show them it was working. R2's January 16, 2019 MDS shows that R2 has no cognitive impairments.

On March 8, 2019 V1 presented investigative interviews and documented that R2 said he "didn't remember if anyone turned the alarm off, and that he did not see anyone turn the alarm off." Her statement continues to show that R2 told V6 that when R1 came into the lobby at around 4:30 AM R1 walked right out the door.

On March 8, 2019 at 5:50 PM, V6 said that the last time he saw (R1) that morning was around 4:30 AM (the police report indicated he told them 4:00 AM), V6 said he was notified by R2, that R1 had left the building and he went to search. V6 said he never heard the door alarm go off that morning. V6 additionally said that R1 had recently (earlier that day) had his 1:1 monitoring stopped and was started on 15-minute checks, but the staff is not always able to do them on time because they may be in with another resident. V6

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S9999	Continued From page 6 stated "he {R1} should have been on a 1:1." On March 8, 2019 at 5:24 PM, V1 (Administrator) said that V2 called me around 5:00 AM and when I got to the building the police were looking for R1. V1 said I don't know how he would walk out of the front door. The alarm was never malfunctioning, and no one reported to me that it may have been turned off. I don't know if it was an alarm malfunction we got a new one. On March 8, 2019 at 4:32 PM, V12 (Receptionist), said that she is the person who sets the door alarm every night at 8:00 PM when she leaves the facility. V12 said she turned the alarm on at 8:00 PM on March 6, 2019 when she left the facility. The surveyor asked V12 what the reason would be the alarm did not sound. V12 stated "the only way that could happen is someone had to turn off the alarm that is the only way it makes sense. The only time the alarm is turned off is during high traffic hours, shift changes, and it probably wasn't turned back on." On March 8, 2019 at 3:50 PM, R1 said I broke out and went out the lobby door. The door was unlocked so I just opened it and no staff were watching me and the alarm did not go off. R1 said I walked a long way and it was cold outside. R1 said I have just been so tired lately I fell backwards and hit my head while I was walking. On May 11, 2019 at 2:00 PM R1 was observed walking in his room and his gait was slow, and debilitating. R1 said that when he went the door he was heading home to Round Lake. According to MapQuest it is 17.2 miles to Round Lake. The path that R1 walked did include heavy traffic, uneven ground surfaces with ice, and road construction.	S9999		

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On May 11, 2019 at 10:46 AM, V13 (Memory Care Director) said if a resident is determined to be high risk they are monitored on a 1:1 for 72 hours. R1's progress notes show on March 4, 2019 at 6:02 PM he was still verbalizing wanting to leave the facility and go home. R1's Elopement Risk assessment completed by V13 on March 6, 2019 at 11:00 AM shows that R1's 1:1 monitoring was discontinued, and he was started on 15-minute checks. (41 hours after verbalizing statements to leave the facility).

On March 11, 2019 at 12:40 PM, V14 (Maintenance), stated he changed out the door alarm and installed a new one on March 7, 2019. V14 said that there was nothing wrong with the old door alarm, he tested it daily and it was working fine on March 6, 2019 and again on March 7, 2019 at 10:00 AM when he checked it. V14 set off a door alarm that was identical to the one that was on the main door at the time R1 left the facility, the alarm was extremely loud and could be heard throughout the unit.

On March 8, 2019, interviews were conducted between 3:45PM and 4:17 PM. V7, V8 both Registered Nurses (RN's), and V9, V10 (CNA's) said that over the past couple weeks R1 had begun showing behaviors of wanting to leave the facility and had recently had 1:1 monitoring reduced to 15-minute checks. V7, V8, V9, V10 said that R1 has unsteady gait, and staff must walk with him to the dining room at the facility. V7, V8, V9, and V10 said that R1 would not be safe walking down the street alone at in night in the cold weather. V7 additionally said that on 2 prior occasions he had to stop R1 from attempting to leave the facility. V7 said that the alarm should have sounded the morning that R1 left the facility if it was turned on.

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Documentations on the 15-minute checks dated March 7, 2019 shows V6 documented that he saw R1 in his room at 4:00AM, 4:15AM, and 4:30 AM. The Police report dated March 7, 2019 page 2 paragraph 4, documents that V6 stated he last saw R1 in his room at 4:00 AM. The same document shows that V6 reported to police he was informed at 4:30 AM by R2 that R1 had left the facility.

On March 11, 2019 at 12:05 PM, V5 (CNA) said that she saw R2 open the door and let the laboratory staff in at about 3:30 AM. V5 said the alarm did not sound. When this surveyor asked V5 why the alarm didn't sound when R2 opened the door V5 stated, "Sometimes the alarm is turned off." V5 said she also did not hear the alarm go off and is not sure if it did go off when R1 went out on the morning of March 7, 2019 because she was in room providing care near the front exit door.

On March 11, 2019 at 1:30 PM, V3 (Assistant Director of Nursing) said the exit door alarm is very loud you can hear the alarm throughout the building. V3 said if you push open the door from the inside the alarm should sound and it should sound until the staff come and shut it off. V3 said that V6 did not hear any alarm he was told by R2 that R1 had left the building. V3 said R2 told her he could not find any staff to report R1's leaving the building. When V6 came to give R2 his medications he told him. V3 said I know the alarm works I tested it 2 weeks ago because we don't want smokers to go out in the cold weather.

On March 11, 2019 at 1:04 PM, R6 said that she had been out on a pass with her boyfriend and returned March 7, 2019 at approximately 12:30

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S9999	Continued From page 9 AM and V5 had let her back into the facility and turned off the alarm. On March 11, 2019 at 2:19 PM, V2 (Director of Nursing) said that they have no formal policy on the door alarm, we just tell everyone. It is expected to be turned on at 8:00 PM every night and turned off at 8:00 AM the next morning when the receptionist comes in. V2 said if the door alarm is turned off a staff person must be sitting right there watching the door. The Accuweather data for March 7, 2019 shows the minimum temperature was 15 degrees Fahrenheit and the high for the day was 25 degrees Fahrenheit and sunrise was at 6:17 AM. MapQuest shows it is approximately 17.2 miles from the facility to Round Lake. (A)	S9999		