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| | IL6010144 | A. BUILDING: _____ B. WING _____ | C 08/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GROVE OF ELMHURST, THE | 127 WEST DIVERSEY ELMHURST, IL 60126 |

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| S 000 | Initial Comments<br><br>Complaint Investigation:<br>2276360/IL150039<br><br>A partial extended survey was conducted. | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violation:<br>300.610a<br>300.1210a)<br>300.1210b)<br>300.1210c)<br>300.1210d)6)<br>300.3100d)2)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.<br><br>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.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>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 | | |

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| S9999 | Continued From page 2<br>Section 300.3100 General Building Requirements<br><br>d) Doors and Windows<br><br>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.<br><br>These Regulations are not met as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to ensure residents identified as risk for elopement were provided adequate supervision to prevent elopement from the facility. The facility also failed to ensure electronic monitoring devices used to alert facility staff to a resident's attempt to elope were in working order and in areas where facility staff could easily hear an audible alarm.<br><br>This failure resulted in R2 eloping from the facility without being witnessed on July 4, 2022, and R1 eloping from the facility without being witnessed on August 10, 2022. Following their respective elopements, R1 and R2 were found by the local police department approximately one-half mile from the facility, across a four-lane, heavily trafficked street.<br><br>This applies to 9 of 9 residents (R1-R9) reviewed for safety concerns in the sample of 9.<br><br>The findings include:<br><br>On August 15, 2022, at 10:45 AM, the facility | S9999 | | |

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|---|---|---|---|---|
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provided an undated list entitled Wander and Elopement Risk Residents. The list identified R1, R2, R4-R9 as residents with wandering behaviors and at risk for elopement. On August 15, 2022, at 1:27 PM, V9 (Lead Social Worker) stated R3, was found "aimlessly wandering by a facility staff member down on the first floor of the facility" on August 15, 2022. V9 continued to say R3 was assessed for elopement risk following the discovery of the resident on another floor of the facility and R3 has now been identified as an elopement risk and will be added to the elopement list as of August 15, 2022.

On August 15, 2022, at 11:04 AM, V6 (Activity Aide) was sitting in the dining room with twelve residents, including R2 and R5. R2 was observed sitting in the dining room, near the exit door, holding a deck of playing cards. V6 had her back to R2. R2 was not interviewable due to his cognitive status. V6 stated she had not been instructed to supervise any specific residents in the dining room. V6 continued to say any resident can leave the dining room of their own free will, and she is not required to notify the nurse if the resident leaves the area. V6 stated she was not aware any residents in the dining room were at risk for eloping. V6 stated she is unsure if the facility has an elopement binder or what a Code Yellow (resident elopement alert) means.

On August 15, 2022, at 10:51 AM, V4 (RN-Registered Nurse) stated she works for a nurse staffing agency. V4 was working on the same floor where R2 resides. V4 stated, "I am not aware of an elopement binder. I do not check to see if a resident's departure alert bracelet is working, or if the resident is wearing the bracelet."

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| S9999 | Continued From page 4<br><br>On August 15, 2022, at 10:55 AM, V5 (CNA-Certified Nursing Assistant) stated she works for a staffing agency. V5 was sitting at the nurse's station outside of the dining room where R2 was sitting, and across from the elevators. "This is my first time working at this facility. I did not receive any elopement training before working today. No one told me about any wanderers. I do not know if any of my residents have a departure alert bracelet on."<br><br>The EMR (Electronic Medical Record) shows R2 was admitted to the facility on March 4, 2021. R2 has multiple diagnoses including, heart failure, cognitive communication deficit, dementia, chronic kidney disease, anemia, delirium, atrial fibrillation, diabetes, and Alzheimer's disease.<br><br>R2's MDS (Minimum Data Set) dated June 30, 2022, shows R2 has severe cognitive impairment, requires supervision with walking, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene. R2 requires extensive assistance with bathing. R2's MDS continues to show R2 does not require the use of a mobility device for ambulation.<br><br>R2's Elopement Risk Assessments dated January 17, 2022, July 8, 2022, and August 15, 2022, show R2 is high risk for elopement from the facility.<br><br>The facility's incident report dated July 4, 2022, shows R2 "Eloped from the facility." Other information on the incident report shows: "[departure alert system] is not working."<br><br>On August 15, 2022, at 3:22 PM, V16 (Police Officer) stated, "On July 4, 2022, I was involved in a traffic stop at the corner of Grand Avenue and | S9999 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| S9999 | Continued From page 5<br><br>York Street, in a grocery store parking lot. This is a very heavily trafficked intersection. [R2] came up to me in the parking lot and wanted to talk. I could see a departure alert bracelet on his wrist and immediately suspected the gentleman was from a local nursing home. I called our dispatcher to see if a nursing home resident was reported missing and was told there were no reports of a missing resident. One of the patrons bringing groceries to her car walked up to me and said she works at the local nursing home and recognized [R2] as a resident from the nursing home. We were able to get the resident into the police car and drove him back to the facility. The area we found [R2] is approximately one-half mile from the facility. When we got to the nursing home, the staff were not aware [R2] was missing."<br><br>On August 15, 2022, at 4:28 PM, V1 (Administrator) stated, "Our security camera footage showed [R2] left the facility through the front door. [R2] walked to the local grocery store parking lot where he was found by a police officer. At the time of the elopement, [R2] resided on the third floor of the facility. The third floor requires access to the elevator using a keypad code. In addition, the elevators also have sensors, inside the elevator, to detect if a resident with a [departure alert] bracelet is on the elevator, but the sensors failed. The elevator sensors are supposed to keep the elevator from moving off the resident floor if a resident is on the elevator with a departure alert bracelet. The elevator sensors have been broken for at least four months. Our facility staff was not aware [R2] was missing until the police showed up at the facility with the resident, following his elopement. I believe the resident high-tailed behind someone leaving the building. I cannot recall if the alarm | S9999 | | |

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sounded or not."

On August 16, 2022, at 11:06 AM, V17 (Agency LPN-Licensed Practical Nurse) said, "On July 4, 2022, I was caring for [R2]. I want to say I last saw him around 7:00 PM. We did not even know [R2] was missing until the police showed up with him. I was going down to the first floor for my break and went to walk out the front door and the police were standing there with [R2] and they said they found him down the street. I know they try to keep [R2] in the dining room with a deck of cards to keep him busy, but he always walks around in the hallways. I am an agency nurse and I think I was assigned to [R2's] resident group once before. I was not told in report that I was caring for any residents who were an elopement risk. Some facilities have elopement binders with pictures of the residents at risk for elopement. I was not told the facility had any type of elopement binder. After the resident returned to the facility, I called the doctor and the family. His daughter was very upset, and she wanted to know why and how this happened, and I told her we would put something in place so it would never happen again."

On August 16, 2022, at 12:09 PM, V18 (NP-Nurse Practitioner) stated, "I examined [R2] the day after his elopement. He was very confused, but I was told this was his baseline. He did not have any visible injuries. I have seen him before in the dining room and he was confused when I saw him previously. He has poor safety awareness."

On August 15, 2022, at 10:30 AM, R1 was sitting in his room with a staff member observing the resident. R1 was not able to be interviewed due to his cognitive status.

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| S9999 | Continued From page 7<br><br>The EMR shows R1 was admitted to the facility on July 21, 2022, with multiple diagnoses including, dementia with behaviors, hypertension, diabetes, and anxiety.<br><br>R1's MDS dated July 28, 2022, shows R1 has severe cognitive impairment, requires supervision with walking, eating, and bathing, and requires limited assistance with bed mobility, transfers between surfaces, dressing and toilet use. The MDS continues to show R1 uses a walker for mobility.<br><br>R1's elopement risk assessment dated August 6, 2022, shows R1 was assessed as high risk for elopement.<br><br>Nursing progress notes show the following documentation regarding R1's elopement attempts and wandering:<br><br>July 22, 2022, at 11:55 PM, by V4 (RN-Registered Nurse), "[R1] wandering into other resident's rooms, attempting to get on elevator with staff stating that he was leaving."<br><br>July 23, 2022, at 5:56 AM, by V20 (LPN) "[R1] up wandering throughout the unit, exit seeking with increased confusion noted ..."<br><br>July 25, 2022, at 4:52 PM, V9 (Lead Social Worker) documented, "It was brought to SS (Social Services) attention that the resident exhibits signs of wandering by attempting to get on the elevator. [Departure alert] bracelet was activated and was given to the floor nurse."<br><br>July 26, 2022, at 8:16 PM, V21 (Nurse) documented, "[R1] is wandering and asking how | S9999 | | |

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| S9999 | Continued From page 8<br>he can find exit doors ..."<br><br>July 29, 2022, at 4:33 PM, V21 (Nurse) documented, "[R1] is wandering."<br><br>August 2, 2022, at 4:37 PM, V9 (Lead Social Worker) documented, "It was brought to SS attention by a nursing staff that resident was attempting to elope from the facility. Social Services intervened by attempting to re-direct and reassure the resident. Social Services escorted the resident back to his room and attempted to call the family member for the resident on his behalf, as the resident was agitated ..."<br><br>August 6, 2022, at 11:13 AM, V22 (RN) documented, "Resident is alert and verbally responsive, talks about his sister that he needs to see, and wanders aimlessly on the unit. Resident attempted to use exit doors so he can go out of the unit. Noted with agitation when reorientation and redirection is provided ...."<br><br>August 10, 2022, at 5:39 PM, V10 (RN) documented, "[R1] was able to get on the elevator and leave the building, a code yellow was initiated with search and rescue. The local police, family member of wife and daughter, the administrator and health care provider made aware. Resident was found by the police at 7:02 PM in the next residential area of Diversey Avenue. Resident stated he was going to see his family ..."<br><br>August 12, 2022, at 10:48 AM, V23 (RN) documented, "Resident noted with anxiety trying to leave unit ...."<br><br>August 14, 2022, at 8:29 PM, V21 (Nurse) documented, "Resident alert, wandering, noted x | S9999 | | |

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| S9999 | Continued From page 9 | S9999 | | |

(times) 1 with anxiety, trying to leave the unit. Resident stated that he is going home and trying to open emergency door ...."

The facility's incident report dated August 10, 2022, shows R1 "was able to get into the elevator and leave the building during med pass time."

On August 10, 2022, at 7:00 PM, V8 (Wound Care Coordinator) documented: "Incident Summary: "[R1] was found in a residential area a few blocks from the facility. EMS (Emergency Medical Service) is present and [local] police officers are present. EMS did an assessment and released resident to the writer and CNA. The resident is alert with confusion, stable and pleasant mood. [R1] states, " I went to take a walk and met these wonderful people and they said I can stay and have supper here." Resident denies pain or discomfort. No signs of respiratory distress were noted. Bruising to the right lower arm."

On August 15, 2022, at 3:22 PM, V16 (Police Officer) stated, "On August 10, 2022, at 6:58 PM, we found [R1] in a residential area, one-half mile east of the facility. The resident had crossed York Street, which is a four-lane, heavily trafficked road, and definitely a very dangerous street to cross. [R1] proceeded to walk east about a half mile, all the way to Willow Road. A resident from a single-family home in the neighborhood stated the resident showed up at their home. The resident from the single-family home invited the resident into their home and they called the police. Our dispatcher knew the name of the resident because the facility had notified the police [R1] was missing. We responded to the home, but [R1] would not come with us in the police car. They had to send some facility staff to

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|---|---|---|---|---|
| S9999 | Continued From page 10 | S9999 | | |

the area to take the resident back to the facility. Our report shows [R1] was last seen at the facility by a CNA around 5:45 PM. We got the call at 6:34 PM, and at 6:58 PM we found him at the single-family home."

On August 15, 2022, at 12:28 PM, V8 (Wound Care Coordinator) stated, "I was doing wound treatments on August 10. The CNA came downstairs and stated a family that was visiting saw [R1] get on the elevator. I was down in the basement and did not see it happen. The CNA and I were told the police had found him and we went to the home where he was found and picked him up. He was wearing a [departure alert] bracelet. He wanders a lot. Usually, he tries to use the end doors on the third floor. Those doors always alarm. Sometimes he tries to follow you on the elevator and go in behind you. Everyone knows he tries to get on the elevator, except families who come to visit at the facility. They would not know that."

On August 15, 2022, at 1:14 PM, V7 (ADON-Assistant Director of Nursing) stated , "I was not surprised [R1] got out. He was always trying to get out."

On August 15, 2022, at 4:03 PM, V10 (RN) stated, "[R1] left the facility while in my care. It was written on the report that he could elope, but no one told me personally that I should keep an eye on him. I last saw him around 5:00 or 5:15 PM on August 10. The CNA came to me and stated she made a bed for him, and she knew he was an elopement risk and could not find him in the dining room and that is when we noticed he was gone. We started looking everywhere for him. We called the police and his family. I heard them saying he went out the basement door. He

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|---|---|
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|---|---|---|---|---|
| S9999 | Continued From page 11 | S9999 | | |

keeps saying he wants to leave and see his family. He was wearing the [departure alert] bracelet that night. I am not sure why the alarm did not go off when he left the building."

On August 15, 2022, at 11:22 AM, V1 (Administrator) stated, "[R1] eloped from the building last week. We assigned a one-on-one sitter to him because he is a high risk for elopement. The sitter is supposed to mark on the log sheet every hour to show they are with the resident. The sensors in the elevator are supposed to keep the elevator from going down if someone enters wearing the [departure alert] bracelet. But the sensors do not work. [R1] was able to take the elevator from the third floor down to the basement and exit from the facility through a back door. The door [R1] exited through is in a vestibule in the basement, and though it has an exit alarm on the door, no staff would be able to hear it there because no staff is in that area, especially after hours. I looked at our security camera footage and the resident left the facility at 5:40 PM on August 10, 2022, undetected by any facility staff. We instituted a new procedure for all of our residents identified as elopement risk. The staff are supposed to mark the elopement log sheets every hour to show they set eyes on the residents because the departure alert sensors do not work in the elevators. The expectation is that staff check on the residents on an hourly basis."

On August 15, 2022, at 10:30 AM, V19 (Agency NA-Nursing Assistant) was sitting in R1's room next to his bedside. V19 stated, "I am doing one-to-one observation of [R1]. Wherever he goes, I go. I started watching him at 7:00 AM today. I am supposed to mark the elopement sheet inside the binder every hour to show I have been watching him."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6010144 | A. BUILDING: _____ B. WING _____ | C 08/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GROVE OF ELMHURST, THE | 127 WEST DIVERSEY ELMHURST, IL 60126 |

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|---|---|---|---|---|
| S9999 | Continued From page 12 | S9999 | | |

V19 showed a binder labeled Elopement. Inside the binder were pages labeled with R1, R2, R5, R6, R7, and R8's name, the date, hourly times, the location of the resident, and the name of the staff member responsible for checking the location of the resident. The pages with R1's name were dated 8/13/2022, 8/14/2022 and 8/15/2022. The page dated 8/13/2022 starting at 7:00 AM did not have documentation to show R1 was observed by facility staff at 9:00 PM, 10:00 PM or 11:00 PM. The page dated 8/14/2022 did not have documentation to show R1 was observed by facility staff from 12:00 AM through 9:00 AM, and 8:00 PM through 11:00 PM. The page dated 8/15/2022 did not have documentation to show R1 was observed by facility staff from 12:00 AM through 10:00 AM.

The EMR shows R3 was admitted to the facility on August 12, 2022, with multiple diagnoses including, heart failure, presence of cardiac pacemaker, hypertension, COPD (Chronic Obstructive Pulmonary Disease), history of TIA (Transient Ischemic Attack) and cerebral infarction, diabetes, anemia, and heart disease.

R3's MDS was not completed at the time of this investigation. On August 12, 2022, at 4:35 PM, V12 (LPN) documented R3 is alert and oriented x2 with occasional confusion.

On August 14, 2022, at 4:03 AM, V14 (RN) documented, "Per endorsement, resident was wandering with only incontinence brief on. Noted to be confused at times."

On August 14, 2022, at 5:43 AM, V14 (RN) documented, "At around 4:30 AM, resident was noted on a wheelchair and ambulating himself by

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GROVE OF ELMHURST, THE | 127 WEST DIVERSEY ELMHURST, IL 60126 |

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| S9999 | Continued From page 13<br>the hallway with only incontinence briefs on. NOD (Nurse on Duty) asked the resident where he was going and resident replied, "I don't know." NOD wheeled the resident back to his room and told the assigned CNA to put the resident back to bed."<br><br>On August 15, 2022, at 5:15 AM, V14 (RN) documented, "Resident came out of room wheeling himself to the hallway. NOD asked the resident if he needed something, resident verbalized "I don't know." NOD told the assigned CNA to bring the resident to his room. Resident was made clean and comfortable. Resident went back to sleep."<br><br>On August 15, 2022, at 1:27 PM, V9 (Lead Social Worker) stated, "[R3] is at risk for elopement. He was wandering aimlessly downstairs, on a different floor than where he resides, without supervision. Another staff member told me about that. It is not until a resident exhibits the behavior of elopement or wandering that we do an elopement risk assessment on the resident, so we have not done one on [R3] yet."<br><br>As of August 15, 2022, at 2:00 PM, the facility did not have documentation to show an elopement risk assessment had been completed for R3 upon admission.<br><br>On August 16, 2022, at 11:53 AM, V9 (Lead Social Worker) stated, "I did the elopement risk assessment on [R3] yesterday around 3:00 PM. The resident did score as a high risk for elopement. Yesterday [R3] was found on the first floor of the facility. He resides on the second floor of the facility and uses a wheelchair for mobility so he would have to go down to another floor using the elevator." | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6010144 | A. BUILDING: _____ B. WING _____ | C 08/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GROVE OF ELMHURST, THE | 127 WEST DIVERSEY ELMHURST, IL 60126 |

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| S9999 | Continued From page 14 | S9999 | | |

The EMR shows R4 was admitted to the facility on August 5, 2022, with multiple diagnoses including, alcohol use with alcohol-induced persisting dementia and history of falling.

As of August 15, 2022, at 9:00 AM, the facility did not have documentation to show R4's elopement risk assessment was completed upon admission to the facility. R4's elopement risk assessment completed on August 15, 2022, at 9:47 AM showed R4 is high risk for elopement.

The facility's undated Wander and Elopement Risk Resident list provided by the facility on August 15, 2022, shows R1, R2, R4, R5, R6, R7, R8 and R9 are at risk for elopement.

As of August 15, 2022, at 10:30 AM the facility did not have documentation to show R1, R2, R4, R5, R6, R7, R8 and R9 were being monitored hourly by facility staff. On August 15, 2022 at 11:22 AM, V1 (Administrator) stated, in order to ensure residents at risk of elopement are safe and accounted for, and because exit alarm sensors located in the elevators are not working, a process was put in place for residents identified as elopement risk are being rounded on hourly by facility staff and documented on log sheets in the elopement binder.

On August 15, 2022, at 11:15 AM, all exits, elevator doors, and departure alert system sensors of the facility were checked with V24 (Maintenance Director). V24 showed departure alert system sensors located in the facility's two elevators, labeled Car #1 and Car #2 were not in working order. V24 stated the sensors in the elevators have not been in working order for about four months. V24 stated he checks the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6010144 | A. BUILDING: _____ B. WING _____ | C 08/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GROVE OF ELMHURST, THE | 127 WEST DIVERSEY ELMHURST, IL 60126 |

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|---|---|---|---|---|
| S9999 | Continued From page 15<br>departure alert sensors Monday through Friday. V24 was unable to say who checks the departure alert sensors on Saturdays and Sundays.<br><br>The facility's departure alert system daily checklists were reviewed for the period May 1, 2022, to August 15, 2022. The facility did not have documentation to show the departure alert sensors were checked in the elevators (Car #1 and Car #2) for the period May 1, 2022, to August 15, 2022. The facility did not have documentation to show all departure alert sensors were checked from June 11, 2022, to June 26, 2022. The facility also did not have documentation to show the departure alert sensors were checked on Saturdays and Sundays for the period May 1, 2022, to August 15, 2022.<br><br>The facility's policy entitled Elopement, revised on July 27, 2022, shows, "Policy Statement: It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement. All residents so identified will have these issues addressed in their individual plan of care. Procedure: 1. Residents who have been assessed at risk for elopement/wandering shall be provided at least one of the following safety precautions by the facility: a. An adult electronic monitoring safety device will be used to notify/alert staff by sounding an alarm when the resident enters the perimeter around an alarmed door. b. Door alarms placed on facility exits. c. Keypad controlled elevators. d. Resident will be listed in the Elopement Book, which will be located at the reception desk and each nursing station. 2. As part of the facility's Preventative Maintenance Program, all doors and elevator | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6010144 | A. BUILDING: _____ B. WING _____ | C 08/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GROVE OF ELMHURST, THE | 127 WEST DIVERSEY ELMHURST, IL 60126 |

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|---|---|---|---|---|
| S9999 | Continued From page 16<br>keypads will be checked for proper function on a daily basis by the Maintenance department/designee. These checks will be documented with date and time completed. 3. Residents with an adult electronic monitoring safety device will be checked every shift to ensure device is in place. 4. Adult electronic monitoring safety devices will be checked weekly to ensure the device is functioning properly. 5. At no time shall a door alarm be turned off, without the continual supervision of the exit. *If the alarm must be turned off, it is the responsibility of the person disarming it to make sure it is functioning properly once the alarm is turned back on. Routine Procedure for Wandering Residents and Prevention of Missing Residents/Elopement: 1. All residents shall be reviewed for safety awareness impairment and elopement/wandering concerns upon admission, readmission, quarterly, significant change in condition and as needed. 4. Residents at risk for elopement shall be identified in the "Elopement Book." The book will have the list of all residents assessed to be at risk for elopement with their name, room number and photo. This book will be located at the receptionist desk and each nursing station. This book will be updated whenever a new resident is added or taken off the list. 5. When a door alarm sounds, staff members shall immediately respond to determine the cause of the alarm. A. The staff person responding to the alarm will check the outside of the building/vicinity of the area to determine if a resident has exited the building. 7. When a resident is found: g. Notify QAPI (Quality Assurance and Performance Improvement) and Risk Management Department of the Elopement Incident."<br><br>All current residents were reassessed for risk of elopement by the Social Services department | S9999 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GROVE OF ELMHURST, THE | 127 WEST DIVERSEY ELMHURST, IL 60126 |

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|---|---|---|---|---|
| S9999 | Continued From page 17 | S9999 | | |

and/or designee and were completed by August 16, 2022. Care plans were initiated and/or revised accordingly for the identified residents and were completed by August 16, 2022.

New admissions will be assessed for elopement upon admission by the nurse and/or designee and an interim care plan will be initiated. The Social Services department will update the elopement risk assessment for all new admissions within 72 hours of admission and update the care plan. Nurses who identify new admissions at risk for elopement will apply the wander bracelet on the resident. Nurses including agency nurses were in-serviced on this procedure on August 16, 2022, and agency nurses will be educated on this prior to the start of their shift.

The identified residents' pictures, face sheets and room numbers are located at each nurse's station and front desk for staff to be able to identify residents at risk of elopement.

A new wander alert system is set to be installed at the facility on August 17, 2022.

R1 and R2 were placed on a 1:1 staff monitoring until August 17, 2022, and until the new wander alert system is installed and functioning completely.

The rest of the identified residents at risk for elopement were monitored every hour by staff starting on August 16, 2022. This will discontinue when the new wander system is fully installed and functional.

A new wander alert system door alarm checklist was implemented on August 16, 2022, and will be completed daily by the maintenance staff during

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6010144 | A. BUILDING: _____ B. WING _____ | C 08/18/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GROVE OF ELMHURST, THE | 127 WEST DIVERSEY ELMHURST, IL 60126 |

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|---|---|---|---|---|
| S9999 | Continued From page 18 | S9999 | | |

weekdays, and by the assigned manager on duty on the weekends. Maintenance staff and managers were in-serviced on this procedure on August 16, 2022.

The Administrator will conduct an audit three times a week for 12 weeks to ensure the wander alert alarm check is being done and that the wander alert alarms are operating appropriately starting on August 17, 2022, or when the new system is fully installed and functioning.

The Social Services department will conduct an audit to ensure that residents identified for risk of elopement have a wander bracelet that is functioning during the weekday. The manager on duty will assume this function on the weekends. All managers were in-serviced on this procedure on August 16, 2022. This will continue daily.

The Administrator or designee will conduct an audit three times a week for 12 weeks to ensure the elopement risk assessments and care plans are completed timely, starting on August 16, 2022.

All staff, including agency staff are being re-educated on, but not limited to, the elopement policy and procedures, where to locate the yellow binders to identify who is at risk for elopement, what to do in the event the door alarm sounds. This will be completed by August 19, 2022, and agency staff will be educated prior to the start of their shift.

All managers have been in-serviced on the new wander alert door alarm check procedures.

An emergency QA (Quality Assurance) meeting was scheduled to discuss the incident and plans

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GROVE OF ELMHURST, THE | 127 WEST DIVERSEY ELMHURST, IL 60126 |

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|---|---|---|---|---|
| S9999 | Continued From page 19<br>of correction with the IDT (Inter-Disciplinary Team) including the Medical Director on August 16, 2022, at 3:00 PM.<br><br>(A) | S9999 | | |