STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008304	A. BUILDING: _____ B. WING _____	C 10/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TERRACE OF MCHENRY REHAB	803 ROYAL DRIVE MCHENRY, IL 60050

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S 000	Initial Comments Facility Reported Incident of 10/7/23/IL165350	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies 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. Section 300.1210 General Requirements for Nursing and Personal Care 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 Statement of Licensure Violations	

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S9999	Continued From page 1 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. (Section 3-202.2a of the Act) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999		

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S9999	Continued From page 2 and assistance to prevent accidents. These Requirements were not met evidenced by: Based on observation, interview, and record review the facility failed to supervise residents on the dementia unit while an exit door was alarming and unlocked. This failure resulted in R1 exiting the building, being picked up by a stranger, and driven away from the facility. This failure has the potential to affect the 17 residents who reside on the dementia unit with wandering or exit seeking behaviors. The findings include: The facility face sheet showed R1 to have diagnoses to include unspecified dementia with other behavioral disturbance, cerebral ischemia (impaired blood flow to the brain) and cognitive communication deficit. The initial nursing assessment dated 6/23/23 shows to be oriented to person only and is considered confused. The facility assessment dated 9/5/23 shows R1 can walk independently. The assessment showed R1 had wandering behaviors daily and required supervision for activities of daily living. A facility incident report dated 10/7/23 showed R1 was found outside the facility by a police officer and was returned to the facility. R1 was described as alert and oriented times one (Person) The facility investigation report showed the staff were redirecting another resident (R2) away from the dementia unit exit door, which was alarmed. R2 was able to push open the door, activating the alarm. The staff were busy dealing	S9999		

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S9999	Continued From page 3 with the behaviors of R2 and feel this is when R1 was able to exit the building un-noticed through the alarming and unlocked exit door. On 10/13/23 at 9:28 AM, V12 responding police officer said the police department received a call at 9:30 AM on 10/7/23. The call was from a citizen who said they had picked up an elderly woman on a busy street near the facility to give her a ride. They quickly realized the person was very confused and called the police. V12 said R1 was picked up by the police about 1-1 ½ miles from the facility in a cul-de-sac of a residential neighborhood. V12 said R1 told him she was going to visit her uncle V but was not even sure what town he lived in, or where she was. V12 said he assumed she was from a nursing home near-by, but she did not know where she lived. V12 said when he asked R1 if she was from this facility, she said yes. V12 then called the facility to notify them of the situation and returned R1 to the facility. On 10/12/23 at 9:05 AM, V11 R1's Power of Attorney-POA, said the family decided to place R1 in a nursing home because she had dementia and was unable to care for herself. V11 said prior to nursing home placement, R1 lived at home with her husband. V11 said R1's husband had a fall and had to go to the hospital. V11 said while R1's husband was in the hospital, R1 called the police two or three times and said she was being held prisoner and they were trying to poison her. V11 said R1 had called the police on herself, because she was the only one there at the time. V11 said R1 and her husband lived in Arizona prior to moving to this state and one day R1 had driven to the store and could not remember how to get home. V11 said he did not know if R1 was cognitively intact enough to safely cross streets	S9999		

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S9999	Continued From page 4	S9999		

on her own. V11 said his fear was that she would be so excited about getting out of the door, that she would take off running and run out into traffic. V11 said R1 had told the family before she was even placed in a nursing home, that if we ever put her into a nursing home she would run into traffic. V11 said prior to being transferred to the current facility, she was at another facility and had an elopement. V11 said the other facility had a wander guard alarm on R1 and she would try to chew it off, tear it off, anything to get it off so she could get out of the facility. V11 said the other facility told him that R1 could not stay there because it did not have a locked unit. V11 said the elopement from the other facility was in June of 2023 and R1 was only there for another week or two before she was transferred to the current facility.

On 10/11/23 at 10:06 AM, V8 Certified Nursing Assistant (CNA) said she was working the day R1 got out of the building. V8 said she had left the unit to go get linens and use the bathroom. V8 said she heard the announcement of the dementia unit exit door being opened so she quick got her linens, used the bathroom, and hurried back to the unit. V8 said when she got back to the unit another CNA was trying to get R2 to settle down and quit trying to hit the staff. V8 said she continued to help R2 until she calmed down and then went to give another resident a shower. V8 said after the shower the nurse told her that R1 had gotten out of the building and was being brought back to the facility by the police. V8 said R1 is ambulatory by herself, likes to wander, and talks about leaving the unit to go home often.

On 10/11/23 at 10:35 AM, V9 CNA said she saw R2 head down towards the exit door at the end of

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S9999	Continued From page 5 the hall, so she followed her down because she knows R2 would try to open the door. V9 said R2 was able to get the door to open before she could stop her. R2 was hitting V9, biting her, and slamming her head back into V9's body. V9 said the nurse came to help her and together they were able to get R2 away from the door and back to the activity room. V9 said she was not able to get the door to stop alarming due to R2's behavior. V9 said the nurse kept trying to get the alarm to stop but was not able to, so the nurse went and got the activity aide to shut the alarm off. On 10/11/23 at 10:50 AM, V6 Registered Nurse (RN) said she was the nurse working on the dementia unit on 10/7/23 when R1 left the building. V6 said she heard the door alarm go off and saw V9 struggling with R2 at the exit door. R2 was hitting, trying to bite V9, and was slamming her head into V9's body. V6 said she went down and helped get R2 away from the exit door and up the hall to the activity room. V6 said she could not get the alarm to stop and was worried about the safety of the staff and R2, so she left the exit door unattended. V6 said as they were bringing R2 away from the door, R1 was observed walking into her room on the same hall of the exit door that was alarming. V6 said the door was not being monitored for approximately 10-15 minutes. V6 said about 15 minutes later, the receptionist called her and told her the police had found R1 walking around outside and were bringing her back to the facility. V6 said she did not know R1 had left the unit. On 10/11/23 at 11:05 AM, V7 Activity Aide said she was doing activities with the residents when R2 was found trying to leave the unit. V7 said she tried to help the CNA's calm R2 down after	S9999		

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S9999	Continued From page 6 she was brought to the activity room. V7 said the nurse asked her if she could go shut off the alarm on the exit door. V7 said she walked down the hall to the door. V7 said there were no staff present at the door and the door had been alarming for 20 to 30 minutes. On 10/11/23 at 11:16 AM, V4 Receptionist said she does not remember what time the call came in as she was busy at the front desk. A call came in and the caller ID said it was the City of McHenry. When she answered, the caller did not identify themselves and just asked if the facility had a resident by the name of a resident not in the facility. V4 said she told them no and they hung up. V4 said about 15 minutes later a police officer called and asked if the facility had a resident by the name of R1. V4 told them yes and V4 said the officer then said R1 was found walking around outside and the officer would bring the resident back to the facility. On 10/11/23 at 2:03 PM, V2 Assistant Administrator said the staff are expected to stay at a door when it is alarming to assure no residents can leave the locked unit. On 10/13/23 at 10:22 AM, V1 Administrator said he expects the staff to reengage the alarm after it alarms and if not able to stop the alarm and reengage the lock, the staff are to stay with the door until it can be relocked. On 10/11/23 at 12:11 PM, V5 Maintenance Director and V1 Administrator showed the surveyor the door that R1 left from. The bar to the door had to be held down for 15 seconds and the door was able to be opened. The alarm sounded to the door. The door did not lock again until the code was entered into the keypad. V1	S9999		

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S9999	Continued From page 7 said once the door is alarmed, it will not engage the lock again until the code is entered. On 10/11/23 at 3:27 PM, V10 R1's Primary Care Physician said he would expect staff to monitor an exit door that is alarming, but not secured, so that other residents with wandering and exit-seeking behaviors cannot get out of the facility. V10 said that is why R1 is at this facility, because she had elopements at the previous facility. V10 said R1 had a wander guard alarm on at the previous facility, but they were so worried she was going to get out again. V10 said that is why R1 was transferred, so she would be safer on a locked unit, and not be able to get out of the facility. The admission resident safety/abuse screening assessment dated 6/23/23 for R1 showed R1 had a history of exit seeking and wandering. The 6/23/23 discharge papers, from the previous long term care facility R1 resided at, showed R1 needs a secure unit because she is self-ambulatory to all destinations without assistive devices. She requires 24-hour supervision. The facility Psychiatric note dated 8/11/23 shows R1 having intermittent behaviors and agitation. R1 was observed ambulating in the facility with increasing agitation and anxiety. R1 was calling staff inappropriate names and hitting the staff. R1 was looking for her husband and demanding to see him. An episodic behavior assessment dated 8/11/23 for R1 showed her to be wandering and attempting to try and leave the unit. The behavior assessment showed R1 was agitated because	S9999		

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S9999	Continued From page 8 she felt she was not fed breakfast. R1 was showing threatening behaviors towards staff and attempted to leave the unit 3 times. R1's care plan dated 7/3/23 showed she had wandering behaviors such as moves with no rational purpose, seemingly oblivious to needs or safety. One of the interventions in place was to remove resident from other resident's rooms and unsafe situations. A care plan for anxiety shows her to wander up and down the halls, asking where her husband is, and asking to go home. The facility investigation into the incident on 10/7/23 showed a note from V6 RN stating she was assisting the staff with a combative resident (R2) who had opened an exit door causing the alarm to sound. V6 stated she saw R1 going into her room, as the emergency exit door was still beeping but she could not get the alarm to stop. V6 then stated she asked another employee to enter the code to shut off the alarm. After the alarm was silenced, she went back to passing her medications and was notified by the front desk that the police had found R1 outside of the building and were bringing her back. The facility provided a list of the residents that are identified as having wandering behaviors on 10/13/23. The facility policy dated 9/2020 for door alarms shows the facility will provide a safe environment for the residents and staff will be provided to assure resident and visitors safety by setting door alarms at all times and re-setting the door alarms immediately after used. The procedure includes: 1. Set door alarms, 2. Monitor alarm panel to assure set, 3. Respond immediately when alarm sounds by checking alarm panel for location of	S9999		

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S9999	Continued From page 9 alarm and proceed to door, 4. Investigate reason for the alarm, 5. Determine if all residents are safe and accounted for, 5. Reset alarm. The facility policy for elopement and management of missing resident dated 3/28/23 shows it is the policy of this facility to report and investigate all reports of missing residents and to minimize risks of elopement. Elopement is defined as a dependent (cognitively impaired, non-decisional) resident leaving a facility without staff awareness and under circumstances that place the residents health, safety or welfare at risk. B. if able to determine the reason for the alarm sounding, reset the door alarm and no further action is needed. B	S9999		