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	IL6003412	A. BUILDING: _____ B. WING _____	C 12/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF NORTHBROOK,THE	263 SKOKIE BOULEVARD NORTHBROOK, IL 60062

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S 000	Initial Comments Complaint Investigation 2499757/IL181724	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 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 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. These requirements are not met as evidenced:	S9999		

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Based on observation, interviews, and record review, the facility failed to follow its "Code Yellow (elopement) Policy" regarding monitoring residents identified as at risk for elopement. This failure resulted in R1 eloping from the facility and being off grounds for an unknown amount of time before a search was started, and a Code Yellow was called.

Findings include:

R1 is a 70 year old female admitted to the facility on 02/09/2023. Diagnosis includes: chronic multifocal osteomyelitis, multiple sites; mild cognitive impairment of uncertain or unknown etiology; gangrene, not elsewhere classified; adult failure to thrive; tachycardia, unspecified; hypotension, unspecified; hypothermia, not associated with low environmental temperature; osteomyelitis,unspecified; schizophrenia, unspecified; hypocalcemia; anemia, unspecified; unspecified severe protein-calorie malnutrition; unvaccinated for covid-19; personal history of covid-19; and patient'snoncompliance with other medical treatment and regimen for other reason.

R1's MDS Section C Brief Interview for Mental Status (BIMS) score is 15 (intact cognition). R1's BIMS on 11/07/2024 is 99 (interview incomplete as R1 chose not to interview).

R1's care plan states R1 is a DNR (Do Not Resuscitate) and has poor decision-making skills and poor judgment. She has been homeless for the past 2 years and was found to be unable to care for herself. She has a court appointed guardian that is in contact with R1 and facility.

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The facility sits in the parking lot of an outdoor mall, and is bordered on three sides by retail outlets and the main entrance faces a major expressway (which has a chain link fence barrier and road shoulder and landscaping before the expressway) making it inaccessible to anyone not physically fit to scale the fence and access the expressway. The facility is corralled on three sides by a privacy fence, so anyone leaving from the "B" doorway would be forced to walk around the fence in front of an external security camera before being able to make it to the bus stops on a busy street (which is about a 5-10 minute walk for an otherwise healthy person).

The facility exit doors all have alarm monitors on them, and are all near a nursing station. There is a keypad on the wall next to the door to deactivate the alarm, or for the staff to disable the alarm prior to exiting and entering the door without setting off the alarm.

Each nursing station and Reception desk was verified to have an elopement/Code yellow book in the nursing station. In addition to the protocol, there was a list of elopement risk residents that were posted in each nursing station. During the time of observation, the "B nursing station" was not occupied. Also, line-of-sight to the doors is not always available, so the alarm is the primary warning system.

The door alarm did sound (when activated by staff activity) during survey, and was only audible within a few feet of the door. Many staff also reported they could not hear the door alarms from other areas of the building when they are not nearby.

Record review and interviews revealed the

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Receptionist is the primary person to monitor the security cameras for the facility. The receptionist also controls the main door for visitors and answers phone calls. The monitoring of the alarm and camera is just one of the responsibilities of the Receptionist, and the desk is monitored by different people on a part-time basis during the week.

On 11/29/24 at 12:40PM, V8, Wound Care Nurse, stated when R1 was first admitted to the facility, she had gangrene to her toes related to frostbite, and was in a lot of pain. R1's wounds were debrided and eventually she was able to move "fast without pain", but she still received daily wound care. V8 stated R1 did not want to go to orthopedic appointments, and she was also recommended for surgery. R1 did have the necrotic skin removed, and she always slept in a chair. R1 would also wear the shoes of her choice instead of surgical shoes. R1 would also refuse treatment from time to time; this was reported to the guardian for R1 and R1's physician. R1 was seen by the Wound Care Nurse on the morning before she left. V8 could not remember the exact time he saw her on that day.

On 11/30/2024 at 2:00PM, V15, Restorative aide, stated V15 was downstairs on the day R1 eloped and she was exercising downstairs with a group of residents. When she came upstairs to assist with lunch with the other residents, that is when V15 found out about the Code Yellow. She did not hear the alarm because of the television that was playing in her group. V15 stated she saw R1 earlier in the day before breakfast, and confirmed her (electronic monitoring) device was working, V15 stated when she is with a group, she cannot leave the group that she is working with to respond to the door alarms. V15 stated leaving

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her group could compromise the safety of the group. V15 verbalized she was able to join the group in the parking lot later and searched the retail stores for R1.

On 11/29/24 at 2:30PM, V11, Certified Nursing Assistant/CNA, stated she saw R1 around 9:00AM on 11/23/24, and then about 5 minutes after that. R1 was on V11's case load that day. V11 remembers a Code Yellow was called around lunch time. V11 verbalized R1 did not need any assistance with her AM routine, so she only saw her briefly, and then would have checked on her again within the next two hours. When asked if two hours had passed since the last time she had seen R1, V11 could not remember. V11 stated she let the LPN (Licensed Practical Nurse) (V5) on the central unit know prior to her going on break, but did not recall hearing the door alarm. V11 could only remember R1 was noticed to be missing based on her lunch tray was untouched around lunchtime. V11 knew the Code yellow protocol and to do a head count during a Code Yellow.

On 11/29/24 at 11:30AM, V5, LPN, stated V5 was the nurse on duty during the elopement. V5 said there were a lot of alarms going off that day. There were deliveries and staff entering and leaving that day. V5 also stated even though the nursing station is right in front of the exit that R1 left from, V5 was "down the hall passing meds to the other residents that she was assigned to", so she did not hear the alarm sounding. V5 knew where the high risk for elopement log for residents on that side of the building. V5 also knew where the names of the high risk residents were posted. V5 knew the Code Yellow protocol, including conducting the head count.

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On 11/29/24 at 2:35PM, V5 added R1 does not have scheduled AM meds; her AM meds are only PRN, so she would not have a time on when she would have seen R1 without passing meds to her.

On 11/29/2024 at 1:41PM, V9,CNA, stated he has been a CNA for about a year, and he normally works on the "D station" and was doing patient care on the day R1 eloped. V9 stated he was looking for a mechanical lift and there was one in the hall near the central exit. V9 apologetically said he heard the alarm when he got the mechanical lift from the hall, and he just turned off the alarm without checking to see if anyone left, or notifying anyone about the alarm. V9 stated he was in a rush to get back to his patient with the lift. V9 verbalized he just "looked at the door" and made a mistake, and feels really bad about it. V9 stated he did not open the door to check out what was going on the outside; he was going through the building looking for someone to assist with the transfer. V9 stated he cannot remember if there was anyone in the "B nursing station" at the time, but he found his supervisor, V10, to assist with the transfer, however, he still did not report to V10 the door alarm was sounding. V9 said V10, CNA, later discovered R1 was missing after lunch. V9 did not see R1 prior to her leaving the facility. V9 is familiar with the Code Yellow procedure and has since been in-serviced on what to do.

On 11/29/2024 at 2:10PM, V10,CNA, stated she went to the bedroom of R1 on the day that she eloped and noticed her breakfast tray was not touched. V10 and her staff then started a search for R1. V10 was not sure about the time, she just knew it was about lunch time, as R1's breakfast tray was delivered to her room. R1 always eats in her room and the tray was untouched. After the

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search, it was determined she was not in the facility, V10 and some other staff started a search of the stores and buildings in the parking lot around the facility. V10 also got into her car and went to Chicago and started checking homeless areas. V10 verbalized she went to the city and started pulling back the blanket of homeless people sleeping on the streets to check for R1. She also asked people on the streets for information about R1. V10 stated she searched until the early hours of the morning, because she wanted R1 to be safe. V10 also verbalized she was in communication with her team of co-workers during the search, but cannot say that her colleagues searched as long as her. V10 said she searched the city based on hunches that she had. V10 stated she did not hear the door alarm prior to V9 disarming it, and V10 was familiar with the Code Yellow policy.

On 11/29/2024 at 2:15PM, V16, CNA who was on duty at the time of the elopement. V16 stated she has worked at the facility for about 2 months as a CNA, on the day in question, V16 heard the door alarm, but was in a room providing care to a resident that is a total care. V16 verbalized she could not stop what she was doing and leave her resident alone. The next time she was alerted to the Code Yellow was from the overhead paging system, which was around lunchtime. V16 then began to search in the shower and around the facility. V16 stated she did go out to the lot and look around, but then came back inside to look in the bathrooms and in the facility. V16 stated she has been trained in the Code Yellow protocol. V16 did indicate she knew the procedure for Code Yellow. V16 was providing care in rooms (room numbers), which were right next to the point of exit for R1.

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S9999	Continued From page 7 On 11/30/2024 at 3:00PM, V18, Recptionist, stated V18 was the Receptionist on duty at the time of the elopement, and no longer works at the facility. V18 verbalized she didn't see R1 leave the facility (via the monitor), or what could have prevented her from seeing R1 leave the facility, as the equipment was functional on the day of the elopement. V18 said when the nurse silenced the alarm, she thought the situation was over. V18 verbalized she did call the Code Yellow when advised, but she was not trained on notifying of the all clear. She stated she has had in-service training, but did not have a clear understanding of the protocol. On 11/29/30 at 10:45AM, V1, Administrator, and V3, Director of Social Services, were interviewed. They discussed facility's efforts to coordinate with local and other municipal police departments, sister facilities, Chicago Transit Authority (CTA) and hospitals, in addition to facility staff members going into the communities to search for R1. V1 described the Code Yellow policy, and how the protocol should have worked. V1 and V3 also described how they started to in-service staff on proper execution of the policy. as well as revisions made to the Code Yellow policy. V1 also stated he was able to view the video of R1 leaving the facility through the door of station "B". V1 was able to describe the clothing R1 was wearing, and that she had taken her belongings in two bags attached to her rolling walker. The video was not saved, and was erased by the camera system "looping" over the video. V3 was able to provide care plans and other documents related to facility policies. V3 also stated she is keeping a log of the efforts to return R1 to the facility. V3 did not share the log, and provided verbal information on progress towards R1's return to the facility. V1 also stated the door	S9999		

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alarms are tested daily by the Maintenance Director.

On 11/29/2024, V1, Administrator, V4, Activities Director, V6, Registered Nurse/RN, V7, CNA, V12, CNA, V13, RN, V14, Social Serivces, and V17, Part-time Receptionist, and all knew the protocol for Code Yellow and how to activate the head count. All workers also verbalized being recently in-serviced on the Code Yellow protocol.

On 11/30/2024 at 12:05PM, V2 (VP of Operations) stated he was informed of the elopement around 1:30PM/2:00PM. V2 stated he was able to contact the CTA (Chicago Transit Authority) via the local police, and was able to determine R1 was near a sister facility and sent worker(s) to CTA facility to retrieve her, but was too late when they got there. It was determined by the CTA that R1 had gone into Chicago. V2 confirmed his team has searched known areas for R1 and homeless people to gather, and maintained contact with hospitals daily.

On 12/01/2024 at 10:00AM, reviewed facility Code Yellow plan, dated 11/01/16 and revised 07/26/24, which reads:
When the door alarm sounds, staff members shall immediately respond to determine the cause of the alarm;
A) The staff member responding to the alarm shall check the outside/vicinity of the area to determine if a resident has exited the building.
B) If upon investigation no reason can be found for the sounding of the alarm the Administrator/DON/designee must be notified.
C) A head count will be completed on all units and completed accounting of all residents given to the administrator/DON

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