| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **145872** | A. BUILDING _____ B. WING _____ | **07/22/2020** |

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

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) |
|---|---|
| F 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review the facility failed to supervise a resident with a history of elopement, and failed to implement interventions to prevent a resident elopement. This applies to 1 of 3 (R15) residents reviewed for safety in the sample of 15. The findings include: R15's Care Plan shows [DIAGNOSES REDACTED]. R15's Nursing Note dated 3/5/2020 at 3:30 PM showed, Resident (R15) is on 1:1 supervision with staff CNA in the parking lot. At approximately (3:30 PM), resident noted running away from assigned staff towards a parked gray sedan car and jumped in. Gray sedan car sped away with an unidentified young Caucasian male . At around (4:00 PM), gray sedan car dropped off resident on the road by the facility entrance .Resident is a high risk for elopement and a danger to self evidenced by wandering to nearby Menards and Lake Cook Rd. without notifying staff, and noted trying to hitchhike. Resident will remain on one on one supervision by staff for safety. All departments aware of risk of elopement. (Note created by V2 Director of Nursing) R15's Nursing Note dated 3/16/2020 at 5:29 PM, documents Resident (R15) escaped this afternoon, returned before dinner .Start 1:1 observation. (Entry created by V18 Licensed Practical Nurse, LPN) On 7/22/2020 at 9:50 AM, V17 stated, in regards to her note from 3/16/2020, I don't remember how long he was gone for; we looked all over; he was gone maybe 20-30 minutes .We were looking for him maybe 20 minutes before we found him. He was on the facility grounds when we found him .When I asked him what he wanted to do he didn't have any plans he just wanted to leave the building . R15's Nursing Note dated 3/16/2020 at 11:00 AM (entry created on 3/17/2020 at 12:25 AM) documents At around 7:40 PM, resident received snacks from assigned CNA doing 1:1 supervision. After 30 mins (minutes), resident (R15) closed his door and stated,I need my privacy. Assigned CNA remains stationed outside his room. Resident was last noted in his room at 8:15 PM. At 8:30 PM, CNA knocked on the door and entered the resident's room and could not locate resident. The window was slightly cracked open and there were loose screws and litter on the floor by the window. Room is located in lower level and windows on ground-level. Code Green (missing resident) was immediately initiated and staff started searching the inside the building and each units and parking lot. At approximately 9:00 PM, resident was found by staff outside the facility .Resident is assessed to be a risk to himself and others and the safety of individuals in this facility is endangered. He is demonstrating poor judgement as evidenced by engaging in activities that can put himself in danger such as wandering, soliciting, hitchhiking. He is exhibiting hyper-manic episodes and is observed with erratic behaviors, non-compliant and resistive to care . (Entry Created by V17, LPN) On 7/22/20 at 1:40 PM, V17 LPN stated, R15 was on 1 to 1 (1:1) observations. V17 stated the CNA (Certified Nursing Assistant) assigned to the 1:1 monitoring notified him that R15 was not in his room. V17 stated R15 said he needed privacy and shut the room to his door. V17 stated, he believed R15 exited his room through his ground floor window. V17 said, given R15's history, I would keep him in site at all times. I don't think he can take care of himself and he is not safe outside the building. V17 stated, R15 made it to Menards. (1.5 miles away) On 7/22/2020 at 11:15 AM, V2 Director of Nursing stated, R15 does not have a Care Plan for elopement/exit seeking behaviors and that he should have one in place. V2 stated, this important because it tells everyone how to care for a resident. V2 said her expectations for 1:1 monitoring is the resident is kept in site at all times. V2 said, if R15 had been under continuous visual observation the elopement could have been prevented and/or staff assistance could have been requested. R15's care plan showed no focus area or interventions for exit seeking behaviors. R15 was not in the facility during this survey. On 7/21/2020 at 3:50 PM, V1 stated R15 was involuntarily discharged from the facility. |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.