STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146169	A. BUILDING _____ B. WING _____	**03/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOUR HEALTH CARE CENTER	**1512 WEST FARGO CHICAGO, IL 60626**

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 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a resident assessed to be at risk for elopement leave their assigned nuring unit undetected, and failed to implement measure for monitoring an exit door in the absence of a security guard, failed to quickly response to alarms alerting staff when a resident with an electronic monitoring device is exiting the facility for 1 of 3 residents (R1) reviewed for elopement prevention. This failure resulted in R1 leaving the third floor nursing unit, and leaving the facility through the first floor front door while the electronic monitoring device alarmed. Findings Include: Incident Report reviewed and reads in part: R1 was noted missing on 3/6/20 at 12:20am. When the staff noted the resident was not in the facility, the inside of the facility was searched and the surrounding areas outside the facility. Staff did not locate the resident. The police were called immediately. Investigation on going. Follow up: R1 returned on 3/6/20 at 6pm, returned by police officer. On 3/11/20 at 9:30am, V1 (Administrator) stated I was alerted about the elopement early in the morning of 3/6/20. I spoke to V8 (Nurse), V8 said he was in room [ROOM NUMBER] providing care when he heard the alarm go off, and V9 (CNA) went to check who triggered the alarm, V9 saw R1 and since R1 can be combative, V9 called V8. V8 went outside to look and R1 had run off. V8 said they called the police and filed the missing person report. Sometime around noon that day we received a call from R1's sister and suggested to look in the area where R1 grew up, which is the Chicago lawn neighborhood. So V8 notified the detective, they checked the area and within 2 hours they found R1 in his grandmother's old house. We have an overnight security guard that happened to called off that night. Security guard stand by the door, monitor behaviors and assist staff with resident with behaviors. When there is no security guard on duty, the nursing staff on the first floor has the responsibility to monitor the front door. The nurses 'station is overlooking the front door. In service was done on 2/27/20 and then we did an elopement drill on 3/4/20, two days before the elopement incident on 3/6/20. Tomorrow is pay day, 3/12/20 all staff will have to take an exam about elopement and pass in order to get their check stab. We also getting quotes from Door Company to put a sliding door in the front which will automatically lock and require a buzz to get in and out, in order to assist the staff with adding security. On 3/10/20 at 2:30pm, V8 (Nurse) stated R1 usually comes down on the floor and hangs around and sometimes he wants to go and smoke, and staff take him outside. The security person is not in the facility that night, and we supposed to have a security guard every night. When there is no security on duty, the nurses on the first floor watched the main entrance. At the time R1 eloped, I was answering call light in room [ROOM NUMBER] and V9 was taking care of another resident. There is no one in the nurse's station watching the entrance door at the time R1 went out of the facility. On 3/11/20 at 10:30am, V9 (Certified Nursing Assistant) stated The last time I saw the R1 was in the hallway, R1 was just pacing around and I redirected him to back upstairs but R1 stayed on the first floor. I went to another resident's room to provide care that was when I heard the alarm went off. No one was monitoring the front door when R1 eloped because the nurse and I were both attending to other residents. We usually have security guard at night to watch the door, but that night the security guard did not come to work. R1 is admitted in the facility on 1/13/20. R1 is with [DIAGNOSES REDACTED]. R1's BIMS (Brief Interview for Mental Status) score is 11 (moderate impaired cognition), from MDS report dated 1/20/20. Elopement Risk Assessment tool with a completed date of 1/17/20 reads in part: Box A, The resident's representative/responsible party requested the resident to be monitored for elopement (Place resident on elopement risk prevention program and develop a plan of care). Physician order [REDACTED]. Care Plan for Elopement/Supervised Pass with schedule date of 2/19/20 reads in part: Focus 1. The resident's representative/responsible party requested the resident monitored for elopement due to resident wondering the floors and standing by the elevator. 2. Resident per physician order [REDACTED]. 3. Resident suffers from mental instability at times, requiring staff assistance and support. Social Services-Psychosocial History Addendum dated 1/17/20, under BRIEF LIFE SKILLS ASSESSMENT section reads in part: Self-Maintenance: 50%+ reduced, Social Skills: 20-50% reduced and Community Living Skills: 50%+ reduced. Based on this assessment, it shows that R1 will not be able to function safely in the community. This puts the resident at risk for injury, while out in the community not supervised by staff. On 3/11/20 at 3:30pm, V5 (Social Worker) explained her assessment on Psychosocial history Addendum dated 1/17/20 as Self maintenance- 50%+ reduced, R1 will need assistance with ADLS. Social skills with 20-50% reduced, R1 was assessed as not able to do well in socializing, talking and communicating with others. Community Living skills, R1 assessed 50%+ reduced meaning R1 needs assistance when out and about in the community. R1 is easily confused on where to go and direction to take, and so he needs assistance in the community. And also needs assistance in taking medication because R1 gets confused easily. R1 knows how to get help but he still needs assistance. Facility Policy Regarding Resident and Elopements reads in part: It is the policy of this facility that all residents are afforded adequate supervision to meet each resident's nursing and personal care need. All residents will be assessed for behaviors or conditions that put them at risk for elopement. All residents so identified will have these issues address in their care plans.

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.