STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145268	A. Building B. Wing	05/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenview Terrace	1511 Greenwood Road Glenview, IL 60025

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 follow its elopement policy by not responding to the wander guard alarm immediately and by not conducting a head count to confirm whether anyone had eloped. The facility also failed to implement the elopement risk care plan interventions, as they did not frequently monitor R1.The Immediate Jeopardy began on 4/23/26 at 9:42:57 pm when R1 exited through the front door.Immediate Jeopardy was identified on 4/28/26. V1 (Administrator) and V13 (Nurse Consultant) were notified of the IJ on 4/28/26 at 12:15 PM. Although the immediacy was removed on 5/1/26, the facility remains out of compliance at a Severity Level II due to the need to evaluate the implementation of policies, procedures, audits, and Quality Assurance monitoring.The Findings include:R1 is an [AGE] year-old male admitted on [DATE] with severe cognitive impairment as per the Minimum Data Set (MDS) dated [DATE]. R1 was admitted to the third-floor locked unit, which required a security key code for elevator access.A review of the elopement risk assessment dated [DATE] documents that R1 was at risk for elopement.A review of the care plan document indicates that R1 was care planned for elopement risk, with interventions including frequent monitoring during his stay in the facility and the use of an electronic monitoring device with R1.A review of the video recording (Camera 05) dated 4/23/26 at 22:01:28 shows R1 began to manipulate with third floor passenger elevator keypad with no staff around him to monitor.A review of the video recording (Camera 05) dated 4/23/26 at 22:05:35 shows R1 continue to manipulate with third floor passenger elevator keypad with no staff around him to monitor.A review of the video recording (Camera 05) dated 4/23/26 at 22:06:12 recorded R1 watching the housekeeper punch key codes to the service elevator while R1 was about 15 feet away from the housekeeper.A review of the video recording (Camera 05) dated 4/23/26 at 22:07:12 shows R1 getting on to third floor service elevatorAn analysis of the video recordings on Camera 05 indicates that R1 was playing around with third floor elevator keypad with no nursing staff supervision for 5 minutes and 50 seconds.On 4/28/26 at 11:00 AM, V1 (Administrator) stated that Camera times on Camera 05 and Camera 15 are not syncing. The real time R1 got on to the third-floor service elevator is 21:41:35 (Camera 05 time 22:07:12)A review of the video recordings (Camera 32) dated 4/23/26 at 21:42:10 shows R1 exiting from the service elevator to the first floor.A review of the video recordings (Camera 15) dated 4/23/26 at 21:42:57 shows R1 exiting through the alarmed door to the outside of the building.A further review of the video recordings (Camera 15) dated 4/23/26 at 21:48:00 showed that the first responder to the alarm showed up at the exit door.An analysis of the video recordings on Camera 15 (first floor exit door) indicates that the first responder (from the first floor) to the wander guard alarm showed up at the exit door after 5 minutes and 3 seconds.On 4/28/26 at 2:00 PM, V3 (Assistant Director of Nursing/ADON) stated, R1 was on high risk for elopement requiring frequent monitoring. The staff should respond to the wander guard alarm immediately upon activation with no delay. The head count should be done as per policy to see if any residents eloped.On 4/28/26 at 12:45 PM, V7 (Night Certified Nursing Assistant/CNA) on 4/23/26) stated, Nobody was aware that R1 was missing. When I made rounds a little after 11:00 PM, I couldn't find R1. I talked to V8 (Agency Nurse) on the PM shift. I (continued on next page)

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.

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

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