STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145429	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wentworth Rehab & Hcc	201 West 69th Street Chicago, IL 60621

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to follow their elopement policy to report an elopement that resulted in R1 eloping from the local emergency and not being located by the facility until a day later to Illinois Department of Public Health, for one [R1] of three residents reviewed for elopement in a total sample of three residents. Findings include:R1's clinical record indicates in part: R1 was admitted on [DATE], with the following medical diagnoses but not limited to non-Hodgkin lymphoma, schizoaffective disorder, syncope and collapse, tremors, convulsions, major depression, essential hypertension, and anxiety disorder. R1's minimum data set [MDS] Brief Interview Mental Status Score Indicates R1 is cognitively intact, alert, and oriented x3.Facility's appointment book:R1 was scheduled for follow up appointment at a cancer clinic withV5 [Restorative Certified Nurse Aide/Escort]. The appointment time was 9:30 AM.R1's Emergency Department Notes, documented in part:R1 was signed in to the emergency room on 6/27/25, at 12:00 PM.At 12:10 PM, R1 had EKG (electrocardiogram) completed.V14 [Hospital Emergency Department Triage Register Nurse] at 12:20 PM, 12:33 PM, and 12:53 PM called R1's name with no answer. R1's EKG results were unchanged, and no acute distress noted. R1 was not seen by a physician in the emergency department.R1's Progress Notes Documented in Part: 6/26/2025, at 12:14 PM, Nurses Note V8 [Licensed Practical Nurse]Note Text: the resident [R1] is out at an appointment for an infusion. The resident [R1] was sent to the ER [emergency department] due to C/O [complaints of] chest pains. 6/27/2025, 10:13 AM, Interdisciplinary Team Note [Administrator V1] Note Text: Writer received call from hospital police [V7 Hospital Campus Security]. V7 provided report #25-00954. V7 called to ensure that this facility had been properly notified that the while receiving care from hospital emergency department the resident[R1] had left the hospital and that the hospital police were making efforts to locate the resident [R1]. V7 inquired if the resident [R1] may have returned to facility and requested any phone numbers, addresses, and contact persons that the facility had on file. Writer provided V7 with all requested information and any background information that the facility had on the resident [R1]. V7 made writer aware that the hospital police would provide any updates. Writer made V7 aware that the facility would do the same. V7 provided writer with phone for any updates. Interviews:On 6/27/25, at 12:07 PM, V8 stated, I was not made aware by hospital staff that R1 was admitted to the hospital. I received a phone call on 6/26/25 around 10:00 AM, from the cancer clinic. The clinic reported R1 was complaining of chest pain and was being send over to the emergency department for an evaluation. I documented the phone encounter at 12:14 PM, because I was busy. I received a second phone call from someone at emergency department, I don't know who I spoke to, but it was a male. This occurred at approximately 2:00 PM. This person reported to me that R1 was missing from the emergency department. The person from the emergency department also stated R1 arrived at the emergency department with an escort but could locate R1 nor the escort. I immediately transferred the phone call to V4 [Assistant Director of Nursing]. When I got off the phone, I did not do anything. I did not call R1's emergency contact [V11], I did not call R1's physician. V4 told me she was going to notify V1 [Administrator]. I received a third phone call from the hospital security campus police around 3:00 PM. The police reported that R1 was missing from the hospital campus and was seen leaving on camera. He notified R1's family member [V11] and made a police report.I received a fourth phone call around 4:00 PM or 5:00 PM. I am not sure of the time, but it was during my evening medication pass. The call was from R1's family member [V11]. V11 reported to me she received a phone call from the hospital and told her that R1 was missing. I told V11, I was sorry to hear that. I did not notify R1's family member [V11] that R1 was missing from the emergency department. I was first made aware of R1 missing around 2:00 PM. I was busy passing out medications. I thought the male I spoke to told me he already had notified V11 and the police. I documented in R1's progress notes today as a late entry for 6/26/2025 12:14 PM, that I received a phone call from the police stating that R1 was seen leaving the hospital on camera. I documented my note wrong. I received a phone call from the hospital security campus police, not the city police department. I also documented I spoke with R1's family member [V11] and made her aware that R1 was missing. I documented that because the hospital security campus police told me they notified V11. I should have documented more clearly. I do not know if the report was made within the hospital or if the report was made with city police department. I documented the note for 12:15 PM, but I am not sure what time I received the phone call.On 6/27/25, at 9:50 AM, V12 [Director of Emergency Department] stated, R1 was seen at the hospital's cancer clinic. R1 was brought over to the emergency department with the

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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. (continued on next page)

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to provide adequate supervision for 1 [R1] of three residents who is an elopement risk. This failure resulted in R1 eloping from the emergency department and not being located by facility staff until 06/27/2025. Findings Include,R1's clinical record indicates in part: R1 was admitted on [DATE], with the following medical diagnoses but not limited to non-Hodgkin lymphoma, schizoaffective disorder, syncope and collapse, tremors, convulsions, major depression, essential hypertension, and anxiety disorder. R1's minimum data set [MDS] Brief Interview Mental Status Score Indicates R1 is cognitively intact, alert, and oriented x/times3.Facility's appointment book:R1 was scheduled for follow up appointment at a cancer clinic with V5 [Restorative Certified Nurse Aide/Escort]. The appointment time was 9:30 AM.R1's Emergency Department Notes, documented in part:R1 was signed in to the emergency room on 6/27/25, at 12:00 PM. At 12:10 PM, R1 had an EKG (electrocardiogram) completed. V14 [Hospital Emergency Department Triage Register Nurse] at 12:20 PM, 12:33 PM, and 12:53 PM called R1's name with no answer. R1's EKG results were unchanged, and no acute distress was noted. R1 was not seen by a physician in the emergency department.R1's Progress Notes Documented in Part:On 6/26/2025, at 12:14 PM, Nurses Note V8 [Licensed Practical Nurse]Note Text: The resident [R1] is out at an appointment for an infusion. The resident [R1] was sent to the ER [emergency department] due to C/O [complaints of] chest pains. Nurses Note V8 [Licensed Practical Nurse] Effective Date: On 6/26/2025, at 14:15:00 [2:15 PM]Created Date: On 6/27/2025, 09:29:31 [9:29 AM]On 6/26/2025, at 2:15 PM, [Documented on 6/27/25 at 9:29 AM]Note Text: Writer received a phone from the police stating that the R1 was seen leaving the hospital on camera. The writer spoke with the resident's mother who is aware of resident leaving the hospital. A police report was made. The physician was made aware as well. [Progress note entered late}. On 6/27/25, at 12:07 PM, V8 said she received phone call from the hospital security not the city police department. A report was made with the hospital security, not with the city police department. On 6/27/2025, at 9:44 AM, Nurses Note V9 {Licensed Practical Nurse] Note Text: Writer received call from ER director [V12-Director Emergency Department] inquiring if resident [R1] returned to the facility. V12 was made aware that resident [R1] has not returned. V12 also asked if resident's mother was made aware and if she heard from the resident. Writer made V12 aware that facility did speak with resident's family member [V11] and she was aware. On 6/27/2025, at 10:13 AM, Interdisciplinary Team Note [Administrator V1] Note Text: Writer received a call from the hospital police [V7 Hospital Campus Security]. V7 provided report #25-00954. V7 called to ensure that this facility had been properly notified that while receiving care from hospital emergency department the resident [R1] had left the hospital, and the hospital police were making efforts to locate the resident [R1]. V7 inquired if the resident [R1] may have returned to facility and requested any phone numbers, addresses, and contact persons that the facility had on file. Writer provided V7 with all requested information and any background information the facility had on the resident [R1]. V7 made the writer aware that the hospital police would provide any updates. Writer made V7 aware that the facility would do the same. V7 provided the writer with a phone for any updates. On 6/27/2025, at 7:29 PM, Nurses Note Restorative [V10- Licensed Practical Nurse] Note Text: While out searching the community for the resident [R1], R1 was observed standing in front of the store at the bus stop. Staff prompted resident [R1] to come back to the facility. R1 was cooperative and agreed to allow staff transport her back to the facility. Administration was made aware.Interviews:On 6/27/25, at 9:40 AM, V8 [Licensed Practical Nurse] stated, I was R1's nurse yesterday [6/26/25]. I worked from 7:00 AM to 7:00 PM. R1 is not here in the facility. R1 had an appointment yesterday [6/26/25] at 9:30 AM. R1 left the facility at 8:30 AM. Approximately a couple hours later, the doctor's office called and said R1 was being sent to the emergency department, due to R1 complaining of chest pain. R1 was admitted to the hospital.On 6/27/25, at 12:05 PM, surveyor asked V8, why didn't she report R1 was admitted to the hospital to the surveyor. During record review of V8's progress note dated 6/26/25, but entered on 6/27/25, at 9:29 AM, surveyor was indicated that V8 documented R1 was missing from the emergency department.On 6/27/25, at 12:07 PM, V8 stated, I was confused, I am sorry. I was not made aware by hospital staff that R1 was admitted to the hospital. I received a phone call on 6/26/25 around 10:00 AM, from the cancer clinic. The clinic reported R1 was complaining of chest pain and was being sent over to the emergency department for an evaluation. I documented the phone encounter late at 12:14 PM, because I was busy. I received a second phone call from someone at emergency department. I