

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Valley HI Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2406 Hartland Road Woodstock, IL 60098	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>35541</p> <p>Based on interview and record review the facility failed to immediately verify a resident (R1) had not eloped from the facility after an exit door alarm sounded. The facility also failed to supervise a resident (R1) in a manner to prevent that resident from eloping from the facility. These failures apply to 1 of 3 residents (R1) reviewed for safety/supervision in the sample of 3.</p> <p>The findings include:</p> <p>R1's progress notes dated 9/8/24 showed R1 was found outside of the facility around 1:30 AM. The notes showed R1 was last seen in bed by staff at 12:45 AM. The notes showed, At 1:12 AM, a (first-floor) door alarm was going off for the northwest courtyard door. Checked the door, no one seen outside, but it was dark. At 1:15 AM, resident not found in bed or bathroom . Search for resident commenced. Resident was seen through window . outside (of facility) by northwest courtyard . The notes showed staff immediately brought R1 back into the building. R1 appeared confused. R1 sustained no injuries or falls during the elopement. R1 was placed on every 15 minutes checks by staff, a wandguard was placed on R1, and a bed alarm was reconnected on R1's bed. R1's physician and POA (power of attorney) were notified of the incident. R1 made no additional attempts to leave the facility on 9/8/24. On 9/8/24 at 7:10 AM, R1 was sent to a local hospital for a psychiatric exam. R1 did not return to the facility.</p> <p>R1's hospital records dated 9/4/24-9/6/24 were reviewed. The notes showed R1 was cognitively intact. R1 resided in his own home prior to his hospitalization for his elective hip surgery. The hospital records showed no documentation of R1 attempting to elope or exit the hospital during his stay.</p> <p>R1's admission note dated 9/6/24 showed R1 was admitted to the facility, from a local hospital, for short-term rehab and therapy. The note showed R1 was cognitively intact.</p> <p>R1's progress notes dated 9/6/24-9/7/24 showed no documentation of R1 exhibiting any exit-seeking behaviors.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/16/24 at 8:09 AM, V4 CNA stated she was R1's CNA from 2:30 PM on 9/7/24 until 7:00 AM on 9/8/24. V4 stated she repositioned R1 in bed around 12:45 AM on 9/8/24. V4 stated, He was alert, not confused for me. Around 12:55 AM, I let the other CNA know that I was going on break. She was on the other wing. I was getting on the elevator, a little after 1 AM, when I heard the door alarm go off but I couldn't stop the elevator door from closing so I went upstairs and did what I had to do. When I came back down (to the first floor), the door alarm was off. I started checking rooms on my floor. That's when I couldn't find (R1) in his room . That's when I let the other staff know he was missing. We started searching the building .</p> <p>On 9/16/24 at 9:15 AM, V8 RN stated, I was in the kitchen area on the first floor when I heard the door alarm go off. I went to the door panel and it showed the courtyard door was alarming. (V7 CNA) and I went over to the door, which appeared shut, and looked out into the courtyard. It was very dark but we didn't see anyone. I silenced the door panel alarm. I went back to what I was doing. A few minutes later, (V4 CNA) returned from her break and let us know she couldn't find (R1). V8 RN stated staff began searching the facility and the grounds of the facility. V8 RN stated about 10-15 minutes later, V7 CNA was found outside the facility by staff. V8 stated R1 was immediately brought back inside the facility and assessed. V8 stated R1 appeared agitated and stated, I must have been sleepwalking. V8 stated R1 had no falls or injuries as a result of his elopement incident. V8 stated, (R1's) room was around the corner from the exit door. I should have gone room to room, on that hall, to make sure everyone was there after the alarm went off.</p> <p>On 9/16/24 at 10:33 AM, V2 Assistant Administrator stated if an exit door alarm is activated, staff are to go the door alarm panel to verify which door is alarming. Once verified, staff are to go to the alarming door, check the door and walk outside to search the immediate area for residents. V2 stated staff should immediately verify the residents, in the rooms near the alarming exit door, are accounted for.</p> <p>The facility's Door Status Annunciator Policy and Procedure policy dated 7/2022 showed, If the door is opened without entering the code or the door had no keypad to enter the code the door will alarm. When the door closes the alarm at that location quits sounding. The door must be checked and reset . Staff shall go to the sounding alarm door, physically check to see if someone had exited by going into the exterior space .</p>		