STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145816	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Lake Zurich	900 South Rand Road Lake Zurich, 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 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** 38488 Based on observation, interview, and record review the facility failed to ensure accurate assessments were completed for a resident at risk for elopement, failed to ensure quarterly elopement risk assessments were completed, failed to ensure a resident at risk for elopement did not leave the facility unsupervised, failed to ensure exit doors were completely shut with alarm activated, and failed to maintain elopement risk signs and book to ensure they were complete and accurate for 2 of 3 residents (R1 and R2) reviewed for elopement in the sample of 19. The findings include: 1. R1's face sheet. showed he was admitted to the facility on [DATE] with diagnoses to include malignant neoplasm of prostate, hypertension, malignant neoplasm of kidney, hypercalcemia, emphysema, cognitive communication deficit and mile protein-calorie malnutrition. R1's facility assessment dated [DATE] showed he had severe cognitive impairment and was independently ambulatory. R1's 8/27/24 Admission Assessment showed, . Elopement Risk Evaluation . 1. No. Resident has the ability to make decision for self and therefore if resident wants to leave facility, it will not be an elopement but could be a discharge or AMA (against medical advice) . R1's 8/29/24 Nursing Note showed he had a wanderguard in place to his left ankle. This note was entered 2 days after R1's assessment that showed he was not a risk for elopement. R1's 9/2/24 Elopement Risk Evaluation showed he was a high risk for elopement. R1's Physician Order Sheet showed an order started 9/12/24 to monitor the placement of R1's wanderguard each shift. No documentation was found regarding monitoring the placement of R1's wanderguard prior to 9/12/24. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's 9/15/24 Incident Report Form showed R1 had eloped the facility and sustained no injuries. The same Incident Report showed, Elopement: . Resident removed his wanderguard by cutting it . Exit door was noted to be unlocked which allowed the resident to leave without activating the alarm . At around 12:45 PM, [another resident] notified first floor nursing staff that while he was smoking on the patio one of the male patients went over the ramp and took off. [The other resident] gave the patients description and the information on which direction the patient was going. [R1] was identified as the patient who took off immediately after a unit search was conducted. Patient was not located within the facility premises in which a code yellow was immediately announced. Nurse assigned drove around the area and noted the patient walking inside the [nearby gas station]. Nurse went inside the gas station/grocery store and approached the patient who at the time was trying to buy a cigarillo. Nurse told the patient that he is not allowed to leave the facility without the staff's knowledge or supervision and that he needs to come back to the facility. At first patient was insisting that he needs to go to the store to buy cigarette. Patient completed his purchase and willingly got inside the nurse's car and returned to the facility without any resistance. Patient remained alert, conversant, not in any distress and with no visible injury noted. Patient was closely monitoring and a new wander guard was applied . Family notified 9/16/24 at 3:10 PM (24 hours after the incident) . Physician notified 9/16/24 at 3:40 PM (24 hours after the incident) . R1's care plan initiated 9/16/24 (the day after R1 eloped from the facility) showed, Wandering/Elopement Risk: [R1] demonstrates movement behavior that may be interpreted as wandering, pacing, or roaming. Attempting to leave the facility without a responsible escort (elopement). The resident is a new admission and not familiar with his/her environment . [R1] to be frequently monitored through next review date . [NAME] to be placed on unit with exit and stairwell alarms . Place personal safety alarm and/or wander alert: on [R1] right leg . Staff to provide [R1] photo for potential for elopement list; staff to educate other staff, to be aware of [R1] wander elopement/risk. On 10/3/24 at 9:57 AM, V9 RN (Registered Nurse) said she was working the day that R1 eloped the facility. V9 said she saw him and chatted briefly at the nurses station. V9 said R1 would walk around the facility taking strolls on the unit and sit in the dining room. V9 said another resident was on the patio having a smoke break and he saw R1 step over the chain across the sidewalk V9 said she believes it was just R1 and another resident out on the patio that day. V9 said when she ran to look at the camera after the other resident reported it R1 left the patio was completely empty. On 10/3/24 at 1:56 PM, V4 (Social Services Designee) said R1 had expressed that he wanted to go home. V4 said the facility was working with R1's son to determine if he was going home to stay with him or if they were considering another facility. V4 said R1 would walk around the facility. V4 said her initial assessment of R1 was on 9/2/24 but she forgot to lock the assessment so it did not flow through to the care plan and she never went and carried it through. R1 said the wanderguard was placed because staff were telling her R1 was lingering around the double doors and verbalizing that he wanted to go home. V4 is unsure of who placed the wanderguard or when it was placed. On 10/3/24 at 2:00 PM, V21 (Social Services Director) said R1 was ambulatory and it was decided he would need a wanderguard. V21 said R1 was usually standing in his doorway or was near the nursing station. V21 said R1 had strong verbalizations about wanting to go home. V21 said R1's room was right across the hall from her office and he would often ask when he was going to be able to go home or state that he wanted to go home. V21 said R1 was not someone that would be able to be unsupervised on the patio. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/24 at 11:37 AM, V18 (R1's son) said the facility called and notified him of R1 leaving the facility on 9/16/24 (the day after the incident). V18 said his dad thought he was in Mexico and was trying to go to somebody's house. V18 said he is not sure when R1's wanderguard was placed. V18 said he picked his dad up one day to go to lunch and he showed him the bracelet on his ankle. V18 said no one at the facility notified him they were placing a wanderguard on R1. On 10/3/24 at 1:47 PM, V2 DON (Director of Nursing) said the patio door has alarms on it. V2 said she believes R1 cut off his wanderguard and went out the patio door with another resident. On 10/3/24 at 2:40 PM, V1 Administrator said she spoke with R1 on 9/16/24 and he said he cut off his wanderguard. V1 said R1 went to the patio with someone else's family member and went out behind them. R1 then stepped over the chain across the exit from the patio and left. V1 said the receptionist has a button to open the patio door. V1 said the receptionist opened the door for the other residents family and R1 trailed them out the door. The facility's policy and procedure revised 7/26/24 showed, Policy Statement: It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement. All residents so identified will have these issues addressed in their individual plan of care . 2. All residents who are at risk for possible elopement/wandering shall be accompanied by staff or responsible part when leaving the residents unit and/or facility grounds . Procedure for missing residents and/or elopements: . Should a resident walk away from the facility and not be located by staff, the following procedure shall be initiated immediately . 4. Contact the resident's family or responsible part and attending physician . When a resident is found: . Document in a nursing progress note the status of the resident on return, including an assessment, evaluation and follow-up actions related to the resident's elopement. 20042 2. The Incident Report Form dated 9/23/24 for R2 showed, she had an elopement but remained in the building. R2 did not sustain any injury. The description of the incident showed, resident was noted walking on second-floor north hallway by nurse V23. V23 called the clinical manager right away to report. Resident was assessed for any injury, nothing was noted. She (R2) stated she was trying to go to her room. She was unaware that she was on a different floor. Resident was escorted back to third floor ambulating without difficulty or pain. The Progress Notes for R2 in her electronic medical record did not show any documentation that she had an elopement from third floor to the second floor or if there were any additional attempts at elopement. The only documentation of the elopement was on the Incident Report form (see above) that was not a part of the resident's medical record. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 11:43 AM, V4 (Social Services) stated she thought R2 eloped from the third floor on 9/23/24 and went to the second floor. V4 stated R2 was not assessed at high risk for elopement when this happened. V4 stated they use wander devices for residents. V4 stated a code has to be entered for the elevator. If a resident with a wander device gets on the elevator an alarm will go off. V4 stated the exit doors if they are pushed on hard enough they will open and an alarm will go off. V4 stated there is a code at the exit doors that can be entered for the alarm not to sound and then the door can be opened. V7 (Memory Care Manager) was present during the interview and stated staff should not put a code in and walk away from the exit doors. On 10/2/24 at 12:16 PM, V8 RN (Registered Nurse) stated she was not working when R2 got off the floor. V8 stated that it was the first time she was aware of R2 doing anything like that. V8 stated she looks at the pictures posted at the nurse's desk to know who is an elopement risk. On 10/3/24 at 10:14 AM, V5 LPN (Licensed Practical Nurse/ acting Assistant Director of Nursing) stated it was on 9/23/24, later in the day, around 5:00 PM and she was on the second floor at the time. V5 stated she saw R2 walking down the hall on the second floor and knew that she was from the third floor. V5 stated she took R2 to the elevator and took her back upstairs. V5 stated R2's room is near the exit door on the third floor. V5 stated she filled out the incident report but did not turn it in to V2 DON (Director of Nursing) until 10/2/24 because V2 had been off sick. V5 stated they do the Incident Reports so they know what happened and what was done to correct it. On 10/3/24 at 11:00 AM, V15 RN (Registered Nurse) stated she did not have any orientation when she came to the facility. V15 stated she heard something beeping when she was in the back hall. V15 stated when she went to the elevator by the nurse's station she saw someone bringing R2 back. V15 stated she has seen many staff not close the exit door tightly and they should so no one gets off the floor. V15 stated R2 was not strong enough to push the exit door open herself. V15 stated the CNA's (certified nursing assistants) are always using the exit door and not shutting it all of the way. On 10/3/24 at 1:47 PM, V2 DON (Director of Nursing) stated if a resident gets out of the building or off their unit/floor they will call a code yellow, it is paged overhead three times. They do a head count and start a search for the resident. When the resident is found a code yellow all clear is announced. V2 stated Elopement Risk Assessments are done at admission, quarterly and as needed. V2 stated it is important to do the assessments to see if someone goes from low risk to high risk so interventions can be put in place such as a wander device. V2 stated the Elopement Risk that is posted and in the elopement books should match and be dated. On 10/3/24 at 2:34 PM, V11 CNA stated she was in the dining room when R2 eloped from the third floor. V11 stated R2 was on her assignment that evening but she had to take her turn monitoring the dining room. V11 stated she was told R2 went out the emergency exit door by her room, was found on the second floor, and brought back to the third floor. V11 stated R2 had a second attempt at an elopement later. R2 was at the nurse's station while she was putting residents to bed because R2 was too awake to go to bed. V11 stated the nurse put R2 in her room and an alarm was heard going off. V11 stated she found R2 at the door trying to leave again. V11 stated the wander devices only work for the elevator. V11 stated the exit doors are alarmed but a code can be put in before opening the door and it disables the alarm for a period of time. V11 stated if the door doesn't shut after awhile the alarm activates again. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Face Sheet dated 10/3/24 for R2 showed diagnoses including Alzheimer's disease, mild neurocognitive disorder due to known physiological condition with behavioral disturbance, adjustment disorder, insomnia, major depressive disorder,, vertigo, paroxysmal atrial fibrillation, moderate protein calorie malnutrition, hypertension, atrial flutter, nontraumatic intracerebral hemorrhage, generalized anxiety disorder, history of falling, syncope, and collapse. R2's Care Plan dated 8/20/24 showed it on 9/25/24 the care plan was updated to include that she is a wandering/elopement risk and attempted to leave the facility without a responsible escort (elopement). R2 demonstrates signs and symptoms of mood distress such as poor appetite, insomnia (often up at night wandering and pacing), and anxiety. The 9/23/24 Elopement Risk Evaluation for R2 showed she has the physical ability to leave the facility, has a firm desire/intent to leave the facility; is not alert, oriented or have the decisional capacity; resident has attempted or has an actual elopement in the last year; roams or wanders throughout the facility and does not respond favorably to staff redirection; resident attempts to leave facility unsupervised and does not respond favorably to staff redirection. Interventions - personal safety alarm device, exit and stairwell alarms, frequent monitoring, identification bracelets, utilization of check in and check out log; recreational activities, music, exercise. The assessment showed there is risk for elopement. The previous elopement risk evaluation was dated 1/17/23 and showed low risk - interventions - exit and stairwell alarms, secured unit, frequent monitoring, identification bracelets, check in/out log, recreational activities . Low Risk 0-3 (stable and is not risk for elopement). R2 did not have any Elopement Assessments between 1/17/23 and 9/23/24. The Facility's Elopement policy (8/27/24) showed, All residents shall be reviewed for safety awareness impairment and elopement/wandering concerns upon admission, readmission, quarterly, significant change in condition, and as needed. Residents identified at risk for elopement/wandering will have a plan of care implemented to address their elopement/wandering behaviors. When a resident is found: initiate elopement precautions, update plan of care, update the Elopement Risk Evaluation, and individualize the interventions for the resident. Designate a staff member to monitor the location of the resident at regular intervals during each shift for 72 hours. Document in a nursing progress note the status of the resident on return, including an assessment, evaluation, and follow up actions related to the resident's elopement. 3. On 10/2/24 at 10:53 AM, there was a sheet of paper posted at the third floor nurse's station labeled Elopement Risk with R1 and R8 - R18's pictures with their name under each picture. There wasn't a date on the Elopement Risk sign that was posted The Elopement Binder at the third floor nurse's station had a different Elopement Risk paper with R2, R8-R10, and R13-R19's pictures with their name under each picture. The Elopement Risk form with pictures in the binder was not dated. The Elopement Risk sign posted at the nurse's station and in the Elopement Book did not match. R1 and R12 were on the Elopement Risk sign at the nurse's desk but not on the Elopement Risk in the elopement book. R2 was not on the Elopement Risk sign hanging up at the nurses desk but was on the Elopement Risk in the Elopement binder. On 10/2/24 at 10:59 AM, V4 (Social Services) stated she updated the Elopement Risk signs that are posted and in the binders. V4 stated she updates the information on Fridays and the updates were not done last Friday (9/27/24) because she had to leave early. V4 was unable to state when the Elopement Risk signs in the binder and posted at the nurses station were last updated and that they were not dated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/24 at 1:47 PM, V2 DON (Director of Nursing) stated the Elopement Risk that is posted at the nurses desk and in the elopement books should match and be dated. The Facility's Elopement policy (8/27/24) showed, residents at risk for elopement shall be identified in the Elopement Book. The book will have a list of all residents assessed to be at risk for elopement with their name, room number, and photo. The book will be located at the receptionist desk or/and each nursing station. The book will be updated whenever a new resident is added or taken off the list.