STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145872	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Long Grove Rehab &hc Ctr	2308 Old Hicks Road Long Grove, 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 - 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** 34506 Based on interview and record review, the facility failed to supervise one of three residents (R1) with a history of exit seeking and at risk for falling, failed to ensure a resident with a history of exit seeking room was not near an exit, and failed to ensure a door alarm sounded when an exit door was opened in the sample of three. This failure resulted in R1 falling down the stairs, experiencing a fibular fracture which contributed to R1 being hospitalized . This failure has the potential to affect all ambulatory residents in the memory care unit. The Immediate Jeopardy began on June 9, 2024 when R1 went out of an exit door and fell down the stairs and obtained a fibular fracture. V1 Administrator was notified of the Immediate Jeopardy on June 19, 2024 at 12:21 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was: Removed, and the deficient practice corrected, on June 10, 2024, prior to the start of the survey.This past compliance occurred from 6-9-24 to 6-10-24. The findings include: R1's Admission Record shows he was admitted to the facility on [DATE] with diagnoses including heart failure, alcoholic cirrhosis of liver, unspecified dementia, morbid obesity, urinary tract infection, anxiety disorders, major depressive disorder, Alzheimer's disease, adjustment disorder with anxiety, glaucoma, and history of falling. R1's Fall Risk assessment dated [DATE] shows R1 is at risk for falls. R1's Nurses Noted dated May 25, 2024 at 10:56 AM, shows resident noted with increased confusion as evidenced by seen by staff in front of the building verbalizing desire to go to the bank. Stated 'I need to go to the bank to check my money.' Re-directed resident but hard to re-direct. Called resident daughter, daughter talked to resident and finally agreed to come inside. R1's Behavior Note dated June 5, 2024 at 1:51 PM shows R1 repeatedly stated that he wants to go home and he can take care of himself and has friends to help him. R1 was confused per baseline. Staff continue to closely monitor R1. R1's Nurses Note dated June 5, 2024 at 4:51 PM shows R1 wanted to leave the unit. R1 kept opening the alarm exit doors. R1 stated he was going to the bank because he is missing money from his checking account. Staff were unable to re-direct R1 and R1 was getting aggressive. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145872	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Long Grove Rehab &hc Ctr	2308 Old Hicks Road Long Grove, 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Care Plan initiated July 3, 2023 shows R1 is frequently trying to leave the unit. R1 frequently wants to go outside to smoke, is frequently resistant to return to the unit after designated smoke times are over and difficult to re-direct. R1's Care Plan intitiated June 8, 2023 shows R1 is at risk for falls: encourage appropriate use of wheel chair. Care Plan initiated January 3, 2024 shows R1 is at risk for elopement related to physical ability to leave the unit/facility. R1 will safely remain on the unit or off under supervision. Monitor behaviors. R1's Physician Progress Notes dated June 6, 2024 shows R1 became confused on May 25, 2024 and was determined to leave the facility to go to the bank. Staff had difficulty redirecting. R1 began treatment for a urinary tract infection and his mentation had not returned to his baseline and R1 remained confused. R1 was moved to the memory care unit at this time. On June 18, 2024 at 2:53 PM, R1's room was noted to be near the exit door that R1 escaped out of. The exit door was around the corner and not visible from the nurses station nor the dining room. R1's Post Occurrence Documentation done by V4 LPN (Licensed Practical Nurse) dated June 9, 2024 at 6:44 PM shows at 3:10 PM, R1 was seen in the hallway in his wheel chair. At 3:20 PM, R1 was heard screaming for help by a staff member. R1 was discovered sitting in the middle of the stairway in a sitting position. R1's wheel chair was at the bottom of the stairway. Per R1, he stated he wanted to go out and smoke. No noticeable injuries were noted. R1 complained of pain to his right ankle and left knee. R1 was left on the stairs until the ambulance arrived. R1's Nurses Notes dated June 9, 2024 at 7:58 PM, shows R1 was admitted to the local hospital with a closed fibular fracture, accidental fall, and urinary tract infection. On June 18, 2024 at 2:46 PM, V14 RN (Registered Nurse) said there was only one recent fall. V14 did not name R1 as a recent fall. At 2:53 PM, the exit door near R1's room was checked for an alarm. R1's room was directly across from the exit door that led to stairs which led to a door to the outside. V14 said the nurses check the alarms on the doors. At 2:55 PM, V14 showed this surveyor the log that includes when the nurses check the alarms on the doors. This log began on June 9, 2024. V14 said this log began after there was an incident involving R1. V14 said R1 was was found in the stairway about 3/4 of the way down the stairs and his wheel chair was at the bottom of the stairs. V14 said that R1 complained of pain to his right leg. V14 said that V4 LPN was R1's nurse that day. V14 said that R1 normally propels himself around the facility while in his wheel chair. Multiple attempts were made to contact V4 unsuccessfully. The facility's Fire Exit Door Alarms log shows it was started on June 9, 2024. The facility's Fall Report dated June 9, 2024 at 3:20 PM, done by V8 RN (Registered Nurse) shows at 3:20 PM, R1 was heard screaming for help by a staff member. R1 was discovered sitting in the middle of the stairway in a sitting position. R1's wheel chair was at the bottom of the stairway. Per the resident, he wanted to go out and smoke. R1 complained of pain to his right ankle and left knee. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145872	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Long Grove Rehab &hc Ctr	2308 Old Hicks Road Long Grove, 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On June 18, 2024 at 4:47 PM, V8 RN said she was sitting at the nurses station learning the computer with V14 RN. V8 said a young man called out and waved to V8 and V14. V8 said the staff member was helping with trays in the dining room when he yelled There's someone yelling for help. V8 said she wasn't sure who the staff member was because she was not familiar with him. V8 said that V8, V14, and V4 went in the direction that the yelling was coming from. V8 said that R1 was down most of the step sitting up. V8 said R1's wheel chair was at the foot of the stairs. V8 said R1 told her he pushed his wheel chair down the stairs. V8 said no one knows how R1 got out. V8 said she did not know if the door that R1 got out of has an alarm on it. V8 said she has heard the alarms go off before and that the alarms are loud. V8 said she does not remember an alarm sounding. V8 said prior to the fall with R1, R1 would always try and leave the unit. V8 said that R1 is a very strong gentleman. V8 said that R1 would try and take advantage of anyone trying to leave through the exit doors. [R1] would try to leave. R1's Hospital Records dated June 9, 2024 shows, Right ankle fracture. Arrived to the emergency room [DATE] from [facility]. He tried to get [out] a door and was in his wheel chair and then fell down seven stairs. Patient was confused in the emergency room disoriented to date and time. He endorsed right ankle pain with no other complaints. A distal fibular fracture was identified. Patient was placed in a fracture boot to the ankle. On June 19, 2024 at 10:20 AM, V15 R1's daughter said the facility put R1 on the memory care unit because they said he would be safer there since he kept trying to leave the facility. V15 said she received a call from the facility on June 9, 2024 saying that R1 got out of the unit and fell down the stairs in his wheel chair. V15 said that R1 was currently still in the hospital and were looking for placement at a different facility. V15 said prior to R1's fall, R1 was able to transfer, but now after his fall he requires maximum assistance to transfer. On June 18, 2024 at 7:18 PM, V3 Medical Doctor said if a resident has a history of trying to leave the facility, then their room should be near the nurses station and not near an exit door. On June 18, 2024 at 4:35 PM, V6 Scheduler/CNA (Certified Nursing Assistant) said R1 likes to go back and forth in the hallways while in his wheel chair. V6 said that R1 is always setting the door alarms off. He's always trying to escape. The facility's Fall Management Policy dated August 2020 shows, The facility is committed to minimizing resident falls and/or injury so as to maximize each resident's physical, mental and psychosocial well being. While preventing all resident falls is not possible, it is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventative strategies and facilitate a safe environment. The facility's Wanderers (Elopement) policy dated September 2020 shows, residents identified as wanderers will have a preventative program to prevent possible injury. A determination is made for a floor and room assignment that will provide increased observation capabilities by staff. The Immediate Jeopardy that began on June 9, 2024 was removed on June 10, 2024 when the facility: -Performed a head count on all units. -All facility door alarms were checked for proper functionality. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145872	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Long Grove Rehab &hc Ctr	2308 Old Hicks Road Long Grove, 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	-All residents, including the resident in question, were assessed for exit seeking behaviors. -The administrator, nurse consultant and medical director reviewed the facility policies related to the occurrence: Door alarms, routine resident checks, and incident/accidents. -The director of nursing/assistant director of nursing and social service have reviewed and updated as need related to patient safety care plans. -The elopement binder was reviewed and updated on June 10, 2024. -All residents deteremined to have exit seeking behaviors have been evaluated for a possible room change to the alarmed unit of the facility. -All residents fall interventions were assessed to ensure proper interventions are in place. -All staff in serviced on the following topics: How to redirect residents that are wandering away from exits, how to promote safer outcomes for residents through supervision, answering door alarms promptly and reporting any changes in cognition or exit seeking behaviors to the nurse. -All staff and managers are being reeducated on routine resident check, incidents/accidents, wandering policy and procedure and where to locate the at risk of elopement binders. -A review of compliance using QA tool for response to door alarms completed on June 9, 2024. -An emergency QA meeting was held on June 10, 2024. The deficient practice was corrected on June 10, 2024 after the facility performed the above.