

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/06/2024
NAME OF PROVIDER OR SUPPLIER  Wealshire Ctr of Excellence		STREET ADDRESS, CITY, STATE, ZIP CODE  150 Jamestown Lane Lincolnshire, IL 60069	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35541</p> <p>Based on interview and record review the facility failed to ensure the safety of a resident when facility staff failed to recognize that a resident (R1), did not return to the facility after being out of the facility on a community/day pass. This failure applies to 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 3.</p> <p>The findings include:</p> <p>R1's care plan dated 4/19/24 showed R1 was admitted to the facility, for rehabilitation, due to a pelvic and hip fracture she sustained from a fall. The plan showed R1 was to walk only with the assistance of staff. R1 required assistance from staff to transfer from surface to surface. R1 propelled herself in a wheelchair. The plan showed R1 was cognitively intact. R1 was homeless prior to her fall.</p> <p>A State Survey Agency Health Care Facility Complaint Form dated 4/30/24 showed R1 was reported missing to a local police department on 4/30/24 at 8:44 PM. The report showed the facility had contacted the local police department to report R1 had been missing since 11:00 AM. The report showed R1 had been signed out of the facility at 10:46 AM, by a friend, but staff was not made aware of (R1) leaving the building and has not been heard from (R1) since. (R1) is entered as a missing person.</p> <p>On 5/1/24 at 1:50 PM, V4 (Police Officer) stated he was called to the facility on the evening of 4/30/24 due to staff reporting a missing resident. V4 stated on 4/30/24, R1 left the facility via wheelchair, on a community pass, with a unknown gentleman around 10:46 AM but as of 8:45 PM that night, R1 had not returned to the facility. V4 stated, The nurses had no idea (R1) had even left the building until later that evening (4/30/24). No nurse had signed her out. V4 reported R1 had been found safe on 5/1/24. R1 was found seated in her wheelchair, outside of a library, in a neighboring town.</p> <p>The facility's Out on Pass Log for April 2024 showed R1 left the building on 4/30/24 at 10:46 AM and returned on 5/1/24 at 2:11 PM. The log showed no nursing signature acknowledging R1 was signing out of the building on 4/30/24.</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>A progress note dated 4/30/24 at 10:47 PM showed nursing staff attempted to locate R1 at 4:04 PM, on 4/30/24, but was unable to locate R1 in the building at that time. The note showed staff were still unable to locate R1 at 8:35 PM. It was at that time that facility nursing staff realized R1 had left the building on a pass at 10:46 AM that morning, but had never returned. Staff then called the local police department to report R1 missing.</p> <p>On 5/2/24 at 8:55 AM, R1 was seated in a wheelchair in the facility. R1 stated she left the facility on [DATE], with a friend to go to a local driver's license facility to get an identification card. R1 stated her friend had an emergency. He couldn't bring me back to the facility so he dropped me off at another friend's house. I slept there. I have a government phone but couldn't call because I didn't have any minutes left. The next morning, I got up and wheeled myself over to the library so I could call and let everyone know I was ok.</p> <p>On 5/2/24 at 10:31 AM, V7 (Receptionist) stated he saw R1 sign out/leave on 4/30/24 at 10:46 AM, but did not report that R1 was leaving to a facility nurse. V7 stated, I did see (R1) leave with her friend. She said she would be returning later that afternoon. I just assumed it was ok for her to go because she had left before. I didn't call her nurse to let them know she was leaving.</p> <p>On 5/2/24 at 10:03 AM, V6 (Nursing Supervisor) stated, A resident must have a physician order to leave the building on a pass. The receptionist is to communicate with us each time a resident is leaving so we are aware. V6 stated that on 4/30/24, I tried to find (R1) around 4:00 PM to give her medications. Staff said she was out. We just thought she was out and about in the building like she always was. She would propel herself around the building in a wheelchair. Around 8:30 PM that night, staff called to tell me that (R1) was still not in her room or on her unit. We searched the building and couldn't find her. It was at that time that we checked the pass log and saw that (R1) had left on a pass that morning. Nursing had no idea (R1) had even left the building. We called (V2 Director of Nursing/DON) at home. She told us to call the police.</p> <p>On 5/2/24 at 11:10 AM, V2 DON stated, The receptionist must check with a nurse before a resident leaves on pass. On 4/30/24, we were not notified (R1) had left the building on a pass that morning. Around 8:30 PM, the staff called me to say they couldn't find (R1). I told them to do a head count and implement the missing resident drill. That's when staff checked the log to discover (R1) had left that morning but had not returned. We called the police to report (R1) had left but did not return. V2 stated facility staff did call R1's friend that picked her up on 4/30/24 to inquire about R1's whereabouts. V2 stated the friend reported that he had dropped R1 off at another friend's house earlier that day.</p> <p>R1's April 2024 Physician Order Report was reviewed. The report showed no physician order giving permission for R1 to go out on a community pass on 4/30/24.</p> <p>On 5/2/24 at 12:20 PM, V9 (Nurse Practitioner) stated R1 needed a new physician order every time she wanted to leave the building on a pass. V9 stated, Even though a resident leaves the building on a pass, they are still our residents. We should know where our residents are at all times including who they are with and if they don't come back. Although (R1) is cognitively intact, she is not physically independent. She is here for rehab. She is in a wheelchair due to her fractures. That's why she can only go out for a few hours with family. She is not to be gone overnight.</p> <p>(continued on next page)</p>		

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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>The facility's Outside Community Pass Privileges Policy dated 3/1/24 showed, Each resident and/or his/her representative is responsible for signing out in accordance with facility policy. Residents who are receiving Medicare Part A benefits will be eligible for out pass by physician. Residents must return to the facility by 8pm unless written permission given by nursing staff as directed by physician orders.</p>		