STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146152	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochelle Gardens Care Center	1021 Caron Road Rochelle, IL 61068

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** 35175 Based on observation, interview and record review, the facility failed to ensure a resident at high risk for elopement did not leave the facility unsupervised for 1 of 3 residents (R1) reviewed for elopement in the sample of 14. This failure resulted in an Immediate Jeopardy. The facility failed to ensure resident safety by timely and accurate documentation of resident monitoring for 14 of 14 residents (R1-14) reviewed for frequent monitoring (15-minute checks) in the sample of 14. The findings include: The Immediate Jeopardy began on 6/18/24 at 11:41 AM when R1 was not visually located in the facility. V1 (Administrator) was notified of the Immediate Jeopardy on 6/28/24 at 8:46 AM. The surveyor confirmed by interview and record review that the immediacy was removed on 6/28/24, but non-compliance remains at a Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. 1. R1's face sheet showed a [AGE] year-old female with diagnosis of Alzheimer's Disease, delirium, vascular dementia, psychotic disorder, and major depressive disorder. R1's 6/23/23 care plan showed to monitor the resident every 15 minutes. R1's 10/5/23 social services note showed 9/2023 behaviors displayed included elopement, wandering, and exit seeking. R1's 2/2/24 and 5/2/24 elopement assessments showed she was at high risk for elopement. R1's 3/29/24 behavior note showed she exited the facility through the A wing door. R1's 5/2/24 cognitive assessment showed she had severe cognitive impairment. R1's 6/18/24 15-minute check log showed no checks from 12:58 AM-4:50 AM, 4:52 AM-9:30 AM, and 9:34 AM-11:25 AM. This record showed 11:26 AM as the last 15-minute check documented prior to R1's exit from the facility. (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
	146152	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochelle Gardens Care Center	1021 Caron Road Rochelle, IL 61068

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 June 2024 behavior monitoring documentation showed she was checked once on 6/1, three times on 6/2, once on 6/3, three times on 6/4, twice on 6/5, twice on 6/6, twice on 6/7, once on 6/8 and wandering was noted, three times on 6/9 with wandering noted, once on 6/10, once on 6/11, twice on 6/12 with elopement/exit seeking behavior noted, three times on 6/13, twice on 6/14, twice on 6/15, once on 6/15, twice on 6/16 with worsened behaviors noted, once on 6/17, and once on 6/18/24. R1's last 6/18/24 documented check was at 11:26 AM (prior to return from the hospital). The local police department 6/18/24 report showed a call was received from a passerby at 12:03 PM. This report showed concern due to the heat and an elderly female walking eastbound on Highway 38 in front of (local restaurant). This report showed the passerby dropped the elderly female off at the police department and appeared disoriented and unaware of where she was. Due to the extreme heat for an unknown amount of time, the local fire department was called to the station. While speaking with the fire department the female was unable to provide any information as to her residence, telephone number, date of birth and claimed she called police but did not have a cell phone with her. The local fire department's 6/18/24 report showed they were dispatched to the police department at 12:38 PM and arrived at the local emergency room at 12:58 PM. This report showed R1 was found along Route 38 near (local restaurant) and suspicion for dementia and being lost was raised. R1 was dressed in a t-shirt, cardigan, and slippers. R1 was insistent she was in Aurora, had no personal effects, was speaking erratically and was confused. R1 was transported to the local community emergency room . R1's local emergency room record showed she was admitted on [DATE] at 1:04 PM with altered mental status. R1 was confused, alert, unsure of time and place, and gave two different names when asked who she was. This record showed she was found wandering on the side of the road. This record showed at 1:19 PM, staff from the facility presented at the bedside. At 1:39 PM, R1 was discharged back to the facility with staff. R1's 6/18/24 12:47 PM health status note (created 6/18/24 at 7:24 PM) showed R1 returned to the facility (was not discharged from ER until 1:39 PM) accompanied by staff. 15-minute checks to continue with upgrade to 1:1 if resident has increased exit seeking behaviors (i.e., stating she will leave to see family). Referrals made to memory care facilities due to this increased behavior by social services/management. There was no documentation in R1's record showing elopement on 6/18/24. The June 18, 2024, at 12:54 PM weather record showed a temperature of 91 degrees Fahrenheit, humidity level of 52% creating a heat index of at least 96 degrees Fahrenheit. An internet search showed (local restaurant) is 0.3 miles from the facility. Route 38 is a busy 4 lane undivided highway between Interstate 39 and Illinois Route 251. On 6/26/24, R1 was observed wandering in the facility. R1 was alert and oriented to person only. R1 was discharged from the facility at approximately 12:05 PM to a facility with a locked unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146152	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochelle Gardens Care Center	1021 Caron Road Rochelle, IL 61068

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 6/26/24 at 8:45 AM, V8 (Registered Nurse/RN) said R1 constantly roams, is usually on 15-minute checks and a lot of times is a sitter (required 1:1 observation). R1 believes she owns the building and opens exit doors. On 6/26/24 at 8:50 AM, V9 (RN) said R1 has wandering as a baseline behavior and has dementia. V9 said on 6/18/24 about 12:40 PM, V12 (V9's family member) called her as she was working in the facility. She asked if we were missing a resident as she picked someone up by (local restaurant) because they looked confused and was walking around with a cardigan on. V12 told her the person said they were on their way to Aurora to see their dad. V9 said V12 told her she took R1 to the police department. V9 said she asked for a description and it matched R1. V9 said she notified V1 of the information. V9 said R1 was a high elopement risk and had gotten out of the facility multiple times. V9 said R1 thinks we're all in her house and doesn't know what we are doing there. On 6/26/24 at 8:59 AM, V10 (CNA) said she was assigned R1's hall on 6/18/24. V10 said she was passing room lunch meal trays to all the halls when a search for R1 was initiated. Passing room trays can take 20-45 minutes depending on what assistance the residents need. Whoever is in the dining room is responsible to ensure all residents come to meals and are accounted for when the CNA is passing room trays. I would still do the documentation (for 15-minute checks) even though I was passing trays. I saw R1 last at 12:00 PM in her room. It's everybody's responsibility to account for the residents. If R1 wasn't in the dining room, someone should have looked for her. On 6/26/24 at 9:07 AM, V4 (Business Office Manager/BOM) said on 6/18/24, she became aware R1 was not in the building around 12:30 PM during or after lunch. R1 had set door alarms off and tried to get out the door in the past. She says she's going to her parents' house in Aurora. V4 said she went to the police department around 12:30 PM and was told R1 was transferred to the local hospital. V4 said she went to the local hospital and brought R1 back to the facility. On 6/26/24 at 9:30 AM, V1 (Administrator) said on 6/18/24, R1 went out one of doors, the A wing door. It was hot and humid that day. There were temporary alarms on the doors. The facility's alarm vendor couldn't come to the facility until 6/19/24. They replaced the keypad on the front door and the fuse that operated the exit door alarm system. V6 (Maintenance Director) does weekly checks on the door alarms. R1 hasn't had exit seeking behaviors since I've been here. She talks about visiting her parents. I haven't known of her to attempt to leave the facility. An attempted elopement or elopement should be documented if you lose sight of the resident. R1 was on 15-minute checks when the elopement happened. When she returned to the facility, I had staff document their 15-minute checks on a paper log. R1 has been accepted to another facility which has a locked unit. She's being transferred there today. On 6/26/24 at 9:40 AM, exit door alarms were checked by V1. The temporary alarms on each door could be disengaged by moving a tab. On 6/26/24 at 10:58 AM, V5 (Dietary Manager) said lunch is served around noon and room trays are brought out at that time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146152	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochelle Gardens Care Center	1021 Caron Road Rochelle, IL 61068

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 6/26/24 at 11:47 AM, V6 (Maintenance Director) said on 6/11/24 he noticed the exit door to his shop wasn't working so he checked all the facility's exit doors. None of the door alarms were working except the door in the main dining room. V6 said he placed temporary door alarms on all exit doors on 6/11/24. V6 said he checks the door alarms weekly and he was not aware R1 had eloped on 6/18/24. The alarms must have been going off. On 6/26/24 at 12:05 PM, V11 (Certified Nursing Assistant/CNA) was passing room trays. On 6/26/24 at 12:12 PM, V11 (CNA) said it takes about 20-25 minutes to pass room trays. On 6/26/24 at 12:46 PM, V13 (head CNA) said if a door alarm is going off you should notify another person, go to the door, and check to see if anyone is outside. V13 said she worked 6/18/24. R1 looks out the front door and says she must get her dog or family members. V14 (CNA) worked 6/18/24 but she's on a plane right now. V15 (Registered Nurse/RN) worked too. On 6/26/24 at 12:50 PM, V10 (CNA) said nobody is assigned your resident checks when you are passing trays. Each is responsible for their own hall. I'm not sure what time they said R1 was missing. I did C wing head counts. On 6/26/24 at 12:58 PM, V1 (Administrator) said it takes about 20 minutes to walk to (local restaurant) from here. We don't really know what door R1 went out. On 6/26/24 at 1:24 PM, V7 (Activity Director) said it takes about 10 minutes to walk to the shopping center where (local restaurant) is located. V7 said on 6/18/24 before lunch R1 said she was looking for her mom and needed to get back to Aurora. R1 does that at least 3-4 times a month. I've seen her go out the front door before. On 6/26/24 at 2:20 PM, V13 (head CNA) said after lunch they began to do a head count. V13 can't remember what time it was but said they were cleaning the dining room. On 6/26/24 at 2:21 PM, V2 (Director of Nursing/DON) said whoever is assigned a resident's hall is responsible to do checks on those residents and document it at the time. If it's not documented, we can't prove it was done. If 15-minute checks are not done, a resident could be gone for an extended period, could cause harm and death. The DON and Administrator are responsible to ensure frequent resident checks are done. We received a phone call on 6/18/24 which prompted a resident head count. They were already looking for R1 since she didn't show up for lunch. Lunch starts around noon. It would take R1 5-7 minutes to walk to (local restaurant). I personally went to (Commercial Store) on 6/11/24 and purchased temporary door alarms. Two alarm packages were purchased, and each package contained four alarms. V6 installed them that day. The facility provided 6/11/24 (Commercial Store) receipt showed the alarms were purchased at 3:21 PM. On 6/26/24 at 2:30 PM, V1 said she did not contact any other alarm vendors. V1 said due to the bankruptcy we aren't supposed to add any new vendors. Corporate knew the alarms were down. We have a lack of equipment. There aren't enough tablets for staff to document their checks as they're being done. The CNAs word is the only proof I can provide that 15-minute checks are being done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146152	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochelle Gardens Care Center	1021 Caron Road Rochelle, IL 61068

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 6/26/24 at 2:59 PM, R5 said sometimes staff check on her every 15 minutes but not all the time. On 6/26/24 at 3:02 PM, R13 said no, staff don't check on him every 15 minutes. It's more like every 8 hours. On 6/26/24 at 3:03 PM, R6 said they (staff) check on me at night to make sure I'm still breathing. I could lay here for hours, and nobody comes in. On 6/26/24 at 3:06 PM, R8 said no, staff don't do 15-minute checks. They check in on me maybe every hour when I'm in my room. On 6/27/24 at 9:53 AM, V1 (Administrator) said the police were not notified of a missing resident. When the facility received a phone call at 12:46 PM, they became aware the resident was at the police station. The facility began a search for R1 on 6/18/24 at 12:15 PM when R1 could not be located to come to lunch. V1 confirmed there was no medical record evidence of R1's elopement on 6/18/24 or of an assessment upon her return. V1 said it was safe to say policies were not followed regarding door alarms and 15-minute checks. When the phone call was received there were still a couple of residents, including R1 that needed to be accounted for. The facility provided list of residents on 15-minute checks as of 6/26/24 at 10:16 AM included R1-R14. 2. R2's face sheet showed a [AGE] year-old male with diagnosis of dementia, traumatic brain injury, restlessness and agitation, chronic viral hepatitis C, adjustment disorder with anxiety, heart disease, hypertension, and epilepsy. R2's 2/27/24 care plan showed he had wandering behaviors and may demonstrate a risk for leaving the facility unattended/elopement related to impaired safety awareness. This care plan showed to monitor his location every 15 minutes. R2's 6/26/24 15-minute monitoring form (printed at 1:45 PM) showed he was checked at 3:26 AM, 3:27 AM, 4:56 AM, 8:48 AM, 8:50 AM, 9:28 AM, 9:50 AM, 10:33 AM, and 1:05 PM. 3. R3's face sheet showed a [AGE] year-old female with diagnosis of psychosis, altered mental status, history of physical and sexual abuse, dementia, and hypertension. R3's 6/23/23 care plan showed she is/has the potential to be inappropriate at times with actions and to monitor every 15 minutes. R3's 6/26/24 15-minute monitoring form (printed at 2:16 PM) showed she was checked at 1:46 AM, 1:47 AM, 4:12 AM, 4:13 AM, 4:54 AM, 8:47 AM, 8:48 AM, 9:28 AM, 9:50 AM, 10:33 AM, 1:04 PM, 1:05 PM, and 2:14 PM. 4. R4's face sheet showed a [AGE] year-old female with diagnosis of schizoaffective disorder, bipolar disorder, pervasive developmental disorder, autistic disorder, anxiety disorder, post-traumatic stress disorder, major depressive disorder, and psychotic disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146152	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochelle Gardens Care Center	1021 Caron Road Rochelle, IL 61068

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	R4's 5/26/23 care plan showed she is known/has history of inappropriate behavior of meeting men online, having them visit her in the facility, and engaging in sexual activity. A 5/26/23 care plan intervention showed to conduct 15-minute checks. R4's 6/28/24 15-minute check documentation (printed at 6/26/24 at 2:14 PM) showed entries for 3:26 AM, 3:27 AM, 4:46 AM, 8:48 AM, 8:50 AM, 9:28 AM, 9:50 AM, 10:33 AM, and 1:05 PM. 5. R5's face sheet showed a [AGE] year-old female with diagnosis of schizoaffective disorder, bipolar type, Picks disease, intellectual disabilities, pseudobulbar affect, psychosis, dementia, encephalopathy, anxiety disorder, and hypertension. R5's 8/18/23 care plan showed she suffered a fall and may be related to lack of safety awareness and poor balance. This care plan showed to monitor her every 15 minutes. R5's 6/26/24 15-minute check documentation (printed at 2:15 PM) showed entries for 1:31 AM, 4:05 AM, 4:43 AM, 5:00 AM, 6:08 AM, 6:59 AM, 7:00 AM, 8:21 AM, 8:30 AM, 9:10 AM, 9:23 AM, 9:32 AM, 9:48 AM, 10:40 AM, 11:11 AM,12:31 PM, 12:48 PM, 1:11 PM, 1:16 PM, 2:02 PM, and 2:15 PM. 6. R6's face sheet showed a [AGE] year-old female with diagnosis of anxiety disorder, insomnia, asthma, rheumatoid arthritis, personality disorder, post-traumatic stress disorder, morbid obesity, hypertension, and peripheral neuropathy. R6's 9/29/23 care plan showed she had risk factors for self-harm and to ensure her safety. This care plan showed R6 was to be supervised on 15-minute checks. R6's 6/26/24 15-minute safety check documentation (printed at 2:15 PM) showed entries for 1:38 AM, 1:39 AM, 4:12 AM, 4:53 AM, 6:08 AM, 6:09 AM, 6:59 AM, 7:00 AM, 8:22 AM, 8:30 AM, 9:10 AM, 9:23 AM, 9:32 AM, 9:48 AM, 10:40 AM, 11:11 AM, 12:32 PM, 12:48 PM, 1:11 PM, 1:16 PM, 2:02 PM, and 2:15 PM. 7. R7's face sheet showed a [AGE] year-old male with diagnosis of schizophrenia, hypertension, epilepsy, schizoaffective disorder, bipolar type, anxiety disorder, and psychosis. R7's 6/23/23 care plan showed he is or has potential to be inappropriate at times with communication and actions. This care plan showed to monitor him every 15 minutes. R7's 6/26/24 15-minute monitoring documentation (printed at 2:16 PM) showed entries for 1:35 AM, 4:08 AM, 4:50 AM, 6:10 AM, 7:01 AM, 8:28 AM, 8:31 AM, 9:11 AM, 9:24 AM, 9:32 AM, 9:48 AM, 10:41 AM, 11:12 AM, 12:39 PM, 12:40 PM, 12:49 PM, 1:12 PM, 1:16 PM, 2:04 PM, and 2:16 PM. 8. R8's face sheet showed a [AGE] year-old female with diagnosis of schizoaffective disorder, major depressive disorder, paranoid schizophrenia, type 2 diabetes, anxiety disorder, bipolar disorder, auditory hallucinations, and obesity. R8's 6/23/23 care plan showed she had impaired ability to understand boundaries and respect for personal property and to monitor her every 15 minutes. R8's 6/26/24 15-minute safety check documentation (printed at 2:17 PM) showed she was checked at 3:29 AM, 3:30 AM, 4:57 AM, 6:13 AM, 9:22 AM, 9:23 AM, 9:24 AM, 9:47 AM, 1:05 PM, and 1:06 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146152	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochelle Gardens Care Center	1021 Caron Road Rochelle, IL 61068

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	9. R9's face sheet showed a [AGE] year-old female with diagnosis of type 2 diabetes, paranoid schizophrenia, morbid obesity, chronic obstructive pulmonary disease, dementia, mixed anxiety disorders, bipolar disorder, and major depressive disorder. R9's 6/23/23 care plan showed she was or had the potential to be inappropriate at times with communication and attire. This care plan showed to monitor her every 15 minutes. R9's 6/26/24 15-minute monitoring (printed at 2:17 PM) showed she was checked at 1:48 AM, 3:24 AM, 3:25 AM, 4:14 AM, 4:55 AM, 8:48 AM, 8:51 AM, 9:28 AM, 9:30 AM, 9:50 AM, 10:33 AM, 1:05 PM, and 2:16 PM. 10. R10's face sheet showed a [AGE] year-old male with diagnosis of polyosteoarthritis, major depressive disorder, hypertension, sepsis, dementia, anxiety disorder, cerebral infarction, and repeated falls. R10's 7/21/23 care plan showed he was at risk for falls and to check him every 15 minutes. R10's 15-minute safety check documentation (printed at 2:18 PM) showed he was checked at 1:34 AM, 1:35 PM, 4:07 AM, 4:08 AM, 4:49 AM, 4:50 AM, 6:09 AM, 6:59 AM, 7:00 AM, 8:23 AM, 8:30 AM, 9:10 AM, 9:24 AM, 9:32 AM, 9:48 AM, 10:40 AM, 10:41 AM, 11:11 AM, 11:12 AM, 12:34 PM, 12:35 PM, 12:48 PM, 1:11 PM, 1:16 PM, 2:03 PM, and 2:15 PM. 11. R11's face sheet showed a [AGE] year-old female with diagnosis of schizoaffective disorder, anxiety disorder, alcoholic polyneuropathy, homicidal ideations, chronic obstructive pulmonary disease, psychosis, and paranoid schizophrenia. R11's 6/23/23 care plan showed she was or had potential to be inappropriate at times with communication and actions. This care plan showed to monitor her every 15 minutes. R11's 6/26/24 15-minute safety check documentation (printed at 2:18 PM) showed she was checked at 1:31 AM, 1:32 AM, 4:06 AM, 4:44 AM, 4:45 AM, 6:09 AM, 7:00 AM, 8:24 AM, 8:30 AM, 9:10 AM, 9:24 AM, 9:32 AM, 9:48 AM, 10:41 AM, 11:12 AM, 12:36 PM, 12:48 PM, 1:11 PM, 1:16 PM, 2:03 PM, and 2:16 PM. 12. R12's face sheet showed a [AGE] year-old male with diagnosis of schizoaffective disorder, type 2 diabetes, hypertension, chronic obstructive pulmonary disease, bipolar disorder, Alzheimer's Disease, Parkinson's Disease, and major depressive disorder. R12's 6/23/23 care plan showed he had the potential to be inappropriate at times with communication and actions. This care plan showed to monitor him every 15 minutes. R12's 6/26/24 15-minute safety check documentation (printed at 2:19 PM) showed he was checked at 1:37 AM, 4:10 AM, 4:15 AM, 4:52 AM, 6:09 AM, 7:00 AM, 8:25 AM, 8:26 AM, 9:10 AM, 9:11 AM, 9:24 AM, 9:32 AM, 9:48 AM, 10:41 AM, 11:12 AM, 12:37 PM, 12:48 PM, 1:11 PM, 1:16 PM, 2:03 PM, and 2:16 PM. 13. R13's face sheet showed a [AGE] year-old male with diagnosis of paranoid schizophrenia, ataxia, osteoarthritis, cognitive communication deficit, type 2 diabetes, hypertension, anxiety disorder, personality disorder, and traumatic brain injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146152	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochelle Gardens Care Center	1021 Caron Road Rochelle, IL 61068

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	R13's 6/23/23 care plan showed he had the potential to be inappropriate at times with communication and actions. This care plan showed to monitor him every 15 minutes. R13's 6/26/24 15-minute safety check documentation (printed at 2:20 PM) showed he was checked at 1:36 AM, 4:09 AM, 4:10 AM, 4:51 AM, 5:00 AM, 6:10 AM, 7:01 AM, 8:29 AM, 8:31 AM, 9:11 AM, 9:24 AM, 9:32 AM, 9:48 AM, 10:41 AM, 11:12 AM, 12:40 PM, 12:46 PM, 12:47 PM, 1:12 PM, 1:16 PM, 2:04 PM, 2:05 PM, and 2:16 PM. 14. R14's face sheet showed an [AGE] year-old female with diagnosis of schizophrenia, bipolar disorder, adjustment disorder, anxiety disorder, cerebral infarction, major depressive disorder, abnormalities of gait and mobility, impulse disorder, and conversion disorder. R14's 6/23/23 care plan showed she was a high fall risk and to do safety checks every 15 minutes. R14's 6/26/24 15-minute safety check documentation (printed at 2:20 PM) showed she was checked at 3:25 AM, 3:26 AM, 4:14 AM, 4:55 AM, 8:48 AM, 8:51 AM, 9:28 AM, 9:50 AM, 10:33 AM, 1:05 PM, 1:11 PM, and 1:12 PM. The facility's undated Resident Monitoring Policy showed the facility may initiate monitoring of residents as a nursing measure to assist in providing safety to residents that are identified to be a potential threat to self or others or an elopement risk. Initiate resident monitoring and document date, time, resident. Behavior, location and (as required) response to interventions. Continue resident monitoring until the Interdisciplinary Team (IDT) can determine the status of the resident and develop appropriate measures for intervention for the resident. The facility's 5/2021 Elopement/Missing Resident Policy and Procedure showed the facility will take reasonable precautions to prevent resident elopement. Notify law enforcement officials and request assistance if the resident is not located on the facility premises. The facility's undated Elopement Policy showed the facility will provide a secure environment in which residents incapable of responsibility for self are protected from wandering outside the facility unattended. If resident absent more than 20 minutes, notify law enforcement. The charge nurse shall complete an incident report, and document all observation, and occurrences in the medical record. The surveyor confirmed by interview and record review that the immediacy was removed on 6/28/24 when the facility took the following actions: 1.) All residents residing in the facility had Elopement Risk Assessment reviewed per the QA team. Those with a High Risk were verified to have their picture and identifiers completed and placed in the Elopement Binder maintained at the nurse's station. 2.) The facility QA team reviewed/revised the Plan of Care for each individual with a High-Risk Assessment. 3.) All staff in the facility are identified as responsible for resident's safety. 4.) All staff was in-serviced by the facility Administrator regarding the facility Door Alarm Policy and the responsibility of all staff to ensure the exit door alarms are activated at all times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146152	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochelle Gardens Care Center	1021 Caron Road Rochelle, IL 61068

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	5.) All staff was in-serviced by the facility Administrator regarding the facility Elopement Policy/Procedures. 6.) All staff was in-serviced by the facility Administrator regarding Missing Resident Policy/Procedures. 7.) All staff was in-serviced by the facility Administrator regarding 15-minute check Policy/Procedures. 8.) Paper logs for 15-minute checks moving on residents on 15-minute checks and one on ones. 9.) During meal services a CNA not conducting hall trays will take over the 15-minute checks during the meal hall pass. 10.) CNAs in the dining rooms will chart the 15-minute checks while that resident is in the dining room. 11.) Facility maintenance personnel will continue to check door alarms weekly. 12.) Facility maintenance personnel will randomly throughout their shift monitor doors to ensure they are engaged. 13.) All staff will be educated during the orientation period of employment as to how to properly turn on and off exit door alarms and to those with elopement risk and location of the information. 14.) Director of Nursing or designee will be responsible for coordination the completion of QA audits to ensure ongoing performance improvement with 15-minute checks and documentation weekly for three months then evaluated by QAPI committee for further audit schedule as needed. 15.) Trends and/or concerns will be reported to the QAPI committee for review and identification of changes in monitoring based on outcomes. 16.) Staff will be in-serviced upon hire and annually to ensure continued compliance.