

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2024
NAME OF PROVIDER OR SUPPLIER Rochelle Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22499</p> <p>Based on observation, interview and record review the facility failed to ensure a resident with severe cognitive impairment, poor safety awareness and a history of elopement was supervised in the facility courtyard after the door alarm did not sound and R4 exited the building. This applies to 1 of 3 residents (R4) reviewed for safety and supervision in the sample of 10.</p> <p>The findings include:</p> <p>R4's Face Sheet dated 10/2/24 shows that R4 has diagnoses including Disorders of the Brain, Adjustment Disorder with Anxiety, Mild Neurocognitive Disorder Due to Known Physiological Condition without Behavioral Disturbance, Epilepsy, Restlessness and Agitation and Dementia.</p> <p>R4's Progress Notes dated 3/3/24 state, Resident left through south C hall exit. CNA (Certified Nursing Assistant) and RN (Registered Nurse) attempted to bring resident back into facility, but resident refused and became aggressive with staff. RN called 911 as RN followed patient two blocks from facility. Police officers called ambulance who then escorted patient to hospital to be evaluated</p> <p>R4's Progress Notes dated 4/28/24 state, Patient eloped out of the activity south exit, jumped the fence and made it to the other side. Staff returned pt back to facility pt continues on 15 min. checks. Staff observing pt at all times from a distance. Patient becomes agitated when staff follow him. Patient seen sitting near exit doors. Frequent redirection required .</p> <p>R4's Progress Notes dated 7/28/24 state, Resident left the building through C hall door. Resident did not want to come back inside because of the nice breeze resident did get physical with the CNA but eventually walked back into the building with therapeutic communication. PRN (as needed) medication given, POA (Power of Attorney) called and resident was able to speak with his son.</p> <p>R4's Progress notes dated 8/24/24 state, Resident was seen by another resident leaving courtyard. Peer notified a nurse and staff was able to keep eyes on resident and redirect resident back into facility. Resident's POA and MD (Medical Doctor) notified. Admin and DON notified. Continue plan of care.</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 10/3/24 at 11:35 AM V14 (RN) stated He likes to run and kind of play tag. He wants us to chase him and he thinks it is funny He got on the roof from a second story window at the last facility he was at. That is what his son told us. We wondered from the beginning why they sent someone with a high risk for elopement to an unlocked facility . He is not safe on his own. He has no idea where he is. He says when he's gonna (sic) go, he's just gonna (sic) go He has a sitter now- he gets some supervised time in the courtyard. One time he ran out the front door and was running around the parking lot. We saw him that time. He hasn't done anything for a while.</p> <p>On 10/2/24 at 2:23 PM V5 (RN) stated, (R4) used to wander more and he got out the door on the other end of the building (7/28/24). (V7- CNA) was here and he stayed with him as soon as we caught up to him. (R4) did not want to come back inside. When the alarm went off, we went running and we saw him in the Hospice parking lot (next to facility)- which is right next door. We have an alarm on the courtyard door too and they just-- maybe 3 weeks ago put a new alarm on the door because the one was not working. I am not aware of him ever getting too far.</p> <p>On 10/2/24 at 2:25 PM V7 (CNA) stated, (R4) went out the C wing door (July 28, 2024). He was in the Hospice Parking Lot. We were able to redirect him to the building but he did not want to come inside. We were with him the whole time. We just tried to give him space. Never heard of him getting far away from the building. For him we just try to redirect, do 1 on 1- often have staff outside in the courtyard or in his hall or we direct him to activities. He is very pleasant and easy to get along with.</p> <p>On 10/2/24 at 11:30 AM V6 (RN) stated, (R4) has been really good lately but he is the one I would be more concerned about. He can be redirected and I think he knows more than he looks like he knows . His son visits occasionally and I wonder sometimes if he isn't a trigger for him trying to leave. We do 15 minute checks on (R4). (R4) I think would just keep going.</p> <p>On 10/2/24 at 2:42 PM V1 (Administrator) stated, . (R4) is on 15 minutes checks. (R4) can run- fast. All the doors are alarmed since the IJ we check them all the time. The care plan should say if high exit seeking then increase to 1 to 1. We are working on discharge for him to a locked facility but we are waiting on the family to go and tour the facility and give us the ok to transfer. Some residents can be alone in the courtyard- (R4) is not one of them.</p> <p>On 10/2/24 at about 2:45PM, V1 stated, the courtyard was locked, and staff had to go around the building to get to the resident. They had to go out the front door and go around the building.</p> <p>On 10/3/24 at 9:35 AM V13 (Maintenance Director) stated, One time a week I check the door alarms. Usually on Wednesdays. About a month ago the courtyard door was not sounding. I do not have an invoice for that repair but I had to call a guy to come out. It was a big repair and I think it had something to do with the speaker. I did my check on Wednesday and either Thursday or Friday the staff on nights reported to me that it was not working. I looked at it and I called the guy on August 19th (Monday). He told me he would either be out the end of that week or early the next week. I would say the repair was done sometime between the 21st and the 28th of August. The keypad was also added at that time.</p> <p>On 10/3/24 at 10:27 AM V1 (Administrator) confirmed that the keypad was put on the courtyard door on August 29th.</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>On 10/4/24 at 12:10 PM V15 (R4's Physician) stated, (R4) must be in a supervised community. He is different every time I see him. Sometimes he has his head under the covers and won't talk to me and sometimes he is very talkative. He has very unpredictable behaviors and should not be out in the courtyard alone. I think it has been a little while since he tried to leave but at first it was quite often.</p> <p>R4's care plan dated 2/27/24 states, The resident has wandering behaviors and may demonstrate a risk for leaving facility unattended/elopement related to impaired safety awareness. Resident wanders aimlessly. The interventions include: Every 15 minute checks (revised on 4/29/24).</p> <p>R4's care plan dated 6/19/24 states, Resident exhibits/has exhibited in past a tendency to seek to leave facility and wander near exits. Specific behavior exhibited< exit seeking and trying to leave facility unattended.>Related diagnoses/condition <dementia>. The Interventions include: 1:1 monitoring until able to DC to locked/secured unit related to elopement attempts (Initiated 8/24/24).</p> <p>R4's Minimum Data Set, dated dated dated [DATE] shows that R4 has Severe Cognitive Impairment.</p> <p>R4's Wandering-Elopement Evaluation Scales dated 5/28/24 and 8/28/24 shows that R4 is High Risk to Wander/Exit Seek.</p> <p>The undated facility policy entitled Elopement states, It is the policy of (corporation) to provide a secure environment in which residents incapable of responsibility for self are protected from wandering outside the facility unattended. This is achieved primarily through door alarms and individual triggering devices.</p>		