STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: ______ B. WING ______	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

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S 000	Initial Comments Complaint Investigation: 2291444/IL143822 2291790/IL144330 Facility Reported Incident of 01/21/2022/IL143704 Facility Reported Incident of 01/30/2022/IL143705	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b) 300.1210 c) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. These requirements are not met as evidenced by: Based on interviews and record reviews, the facility failed to implement the 15 - minute monitoring on a resident with a behavior of trying to leave the facility without permission. This deficiency affects one (R2) of three residents reviewed for accidents and supervision. This deficiency resulted in R2 exiting and eloping the facility; R2 was found in the hospital emergency room and sustained a bruise to the right knee with soreness, two small scabs to the base left index and middle finger, left knee tenderness, minor swelling on left foot, and pain to his left bottom of foot under great toe. Findings include: R2 is a 39-year-old, male, admitted in the facility on 01/28/2022 with diagnoses of Other Encephalopathy; Anoxic Brain Damage, Not Elsewhere Classified; Heart Failure; Generalized Anxiety Disorder; Cognitive Communication Deficit; Dysarthria and Anarthria; History of Falling and Other Lack of Coordination. R2's progress notes documented the following in part but not limited to the following: 01/29/22 - noted with all his belongings in a	S9999		

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S9999	Continued From page 2 plastic bag and with his red backpack on. When asked where he was going, he stated "I am going to school." 15-minute check initiated. 01/30/22 time stamped 7:59 AM - remains on 15 minutes checks. Per day shift report, R2 was trying to leave facility with a backpack to go to school. 01/30/22 time stamped 4:50 PM - R2 is missing from his room. Code green for elopement was initiated throughout the facility. Call placed to nearest hospital and R2 is in the emergency room (ER). 01/30/22 time stamped 7:50 PM - arrived at facility at 7:45 PM. Head to toe assessment done and shows a bruise to right knee. On 03/14/22 at 12:20 PM, R2 was asked regarding recent incident of getting out of the facility without supervision and permission. R2 verbalized, "I don't remember. I don't have any idea. This is the first time I've been hearing about this. I go to school, it is pretty horrible, right?" R2 does not have a recollection regarding the incident. R2's cognitive level cannot provide direct answers. On 03/15/22 at 12:48 PM, V4, (Licensed Practical Nurse, LPN) was asked regarding incident on 01/30/22 with R2. V4 stated, "On 01/30/22, I was doing wound care down the hall. V5 (Certified Nurse Assistant, CNA) checked his room, and he was in his room. It was around 4:30 PM, V15 (Family Member) came into the facility and was told that he (R2) was not in his room. I checked his room; he was not there. We checked the hallways; he was not there. We called for a code green and followed the protocol, notified V7 (Social Services Director), manager on duty; local authorities were called. The whole facility was on lockdown and notified V1 (Administrator) and V2	S9999		

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(Director of Nursing). I actually called hospital and was told that they don't have a patient by that name. After about 15 minutes, V15 received a phone call from the said hospital stating he (R2) was there, unharmed, in the emergency room. He (V15) went over, said that he (R2) had a fall and had a scrape on his left knee. X rays and scans were done, all negatives and he came back. He was moved to third floor. The day before, he was noticed in front of the elevator, standing, with a backpack, stating he is going to school. I did notice it. I initiated a 15-minute check and notified the manager on duty V11 (Restorative Nurse). That's the only intervention we did, the 15-minute check. We document it manually in the 15-minute check sheet." V4 was also asked if the 15-minute check was implemented consistently. V4 replied, "January 30 was a Sunday. It happened between 4 PM to 4:30 PM, two CNAs (V5 and V6) and two nurses (V4 and V16) working on the first floor. Both CNAs (V5 and V6) went to the lower level to prepare the trays for the first floor residents, that takes about 30 to 40 minutes. I was in the room with a patient with a wound that was bleeding. I don't know with the other nurse (V16) on what she was doing at the time. The 15-minute check within the 30 to 40 minutes was not done, so he (R2) was able to go down lower level. The activity aide (V17) saw him (R2). She (V17) asked him where he was going, He (R2) said he was trying to go outside. She (V17) said "It's cold outside, you don't have a coat." She (V17) brought him upstairs to the front desk. V7 was at the front desk. Then he (R2) disappeared."

V5 was also asked regarding R2 on 03/15/22 at 1:35 PM. V5 verbalized, "I was the CNA that time when the incident happened on 01/30/22 when he eloped. He was on a 15-minute check. I was doing a 15-minute check by going to his room, do

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my rounds on him and document in the 15-minute check sheet. I was at the lower level with V6 to set up the 5:00 PM dinner. I told V4 that I will be going down, the last check I did was 4 or 4:15 PM, he (R2) was in his room. I don't know what happened next, all I knew was when I came upstairs with foods, there was a code announcement for a missing person."

On 03/15/22 at 1:51 PM, V6 was asked regarding incident on 01/30/22 when R2 was missing. V6 replied, "Me and V5 were in the lower level café, serving dinner to other first floor residents. It was around 4:30 to 5:00 PM when we came down there, took about 45 minutes to serve and then prepare our room trays - all in all, it would be between an hour to an hour 15 minutes. The nurses know that we are down in the cafe, and they should be doing the monitoring of the residents."

On 03/16/22 at 11:16 AM, V16 (Registered Nurse, RN) was asked regarding R2. V16 stated, "I was not his nurse that time. I was not aware that he was an elopement risk, he was not my patient that time. He was V4's patient. I was not involved in the monitoring. There was no endorsement from other staff for me to monitor him (R2)."

On 03/15/22 at 2:10 PM, V7 (Social Services Director) was interviewed regarding R2. V7 stated, "I was at the front desk, I was the Manager on Duty that Sunday, 01/30/22. V17 brought him (R2) to me. I took him to his room, and he went to bed. I went back to the front desk. I was preoccupied with phone calls and attending to family members that I did not notice on when he (R2) actually exited the building. I was not aware that he (R2) had a behavior of trying to

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elope. I don't know what exactly happened, on how he was able to exit the building."

Facility's 15 - minute checks dated 01/30/2022 indicated that the last time R2 was monitored was between 3:15 PM to 3:30 PM. There were no succeeding records that he (R2) was monitored after 3:30 PM until facility noticed that he (R2) was already missing.

On 03/15/22 at 2:34 PM, V2 (Director of Nursing) was asked regarding expectations on staff in preventing elopement on residents. V2 replied, "Staff has to monitor residents every 15 minutes for elopement risk residents, if they attempt to elope."

On 03/16/22 at 2:35 PM, V19 (Nurse Practitioner) was interviewed regarding R2. V19 verbalized, "He is really young, a lot of health conditions. He is pretty confused at times; he can talk but really confused. He cannot make a conversation with directions. He has cognitive disorder. He has difficulty expressing himself. He cannot go out alone without supervision. He will get lost, can get into an accident and might injure or hurt himself. Last time, like when he was just admitted, he eloped. I got a call from one of the nurses stating that he eloped. I was not aware that prior to his elopement incident that he was already attempting to leave the facility. Staff needs to watch him closely every 15 minutes if this is a facility's elopement prevention call; everyone should be aware that he is a high risk patient for elopement. I know that first floor where he was might be busy, but I don't know why they missed it, don't know what happened, but he should be watch closely. If it is every 15 minutes, then he should be monitored every 15 minutes. He is not capable of caring for himself."

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S9999	Continued From page 6 According to R2's progress notes dated 01/31/22, he was noted with a bruise to right knee, and complained of soreness. He was also noted with two small scabs to base left index and middle finger; has skin tags to his left upper arm. His left knee is tender and left foot has minor swelling. He was complaining of pain to his left bottom of foot under great toe. Facility's policy titled "Missing Resident" dated 09/2020 does not address interventions in preventing incidents of elopement in the facility. Facility's policy titled "Incident/Accident Reports For (name of State) Facilities" dated 09/2020 stated in part but not limited to the following: Procedure: An accident refers to any unexpected or unintentional incident, which may result in injury or illness to a resident. This does not include adverse outcomes that are a direct consequence of treatment or care that is provided in accordance with current standards (example, drug side effects or reaction). 3. All unusual occurrences. 4. All situations requiring the emergency services of a hospital, the police, fire department, or coroner. 15. Facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents (B)	S9999		