Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: ______ B. WING ______	C 12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

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S 000	Initial Comments Investigation of Complaints: 2279743/IL154093 2279698/IL154097	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements were not met evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident identified as a high risk for elopement was provided adequate supervision to prevent elopement from the facility. This failure resulted in	S9999		

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R1 eloping from the facility without being witnessed on December 8, 2022. R1 was found across a six lane busy road at a gas station and required warming with blankets from emergency medical services. R1 was found at approximately 4:57 AM. This applies to 5 of 5 residents (R1-R5) reviewed for safety and supervision from the total sample of 16.

The findings include:

On December 9, 2022, at 10:47 AM, the facility provided an undated list entitled "At Risk of Elopement." The list identified R2-R16 as residents at risk of elopement who were residing on the first floor. On December 9, 2022, at 10:20 AM, V2 (DON) said staff are to perform every 30 minute observations on residents who's BIMS (Brief Interview for Mental Status) Score decreases and if the resident is not residing on the third floor of the facility.

At the time of R1's elopement, V9 (RN/Registered Nurse) and V10 (CNA/Certified Nursing Assistant) were the staff members working on the unit R1 resided. V9 and V10 were responsible for monitoring 44 residents, and of the 44 residents, 16 residents required every 30 minute observations.

1. The EMR (Electronic Medical Record) showed R1 was admitted to the facility on September 28, 2017, with diagnoses including: chronic kidney disease, dementia, and atrial fibrillation.

R1's MDS (Minimum Data Set) dated October 4, 2022, showed R1 was moderately cognitively impaired and required supervision of facility staff for locomotion on and off the unit.

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R1's elopement care plan revised on December 8, 2022, showed "[R1] is noted to have short term memory deficits and having difficulty in recall. [R1] is sometimes/often exploring/elopement/exit seeking as evidenced by: can't find place he wants to go. Attempts to get on elevator. Attempts to use alarmed, fire exit doors." The care plan continued to show multiple interventions date February 17, 2022, including, "Orient resident to surroundings and situation as needed."

Facility documentation titled, "Exit Seeking/Wandering/Elopement Risk Assessment," dated October 4, 2022, showed R1 was at risk for elopement.

On December 9, 2022, at 10:20 AM, V2 said R1 eloped from the facility using a side exit door. V2 continued to say R1 said he left the facility to go buy a soda.

On December 9, 2022, at 1:40 PM, V9 (RN) said she was working when R1 eloped. V9 said the last time she saw R1 was around 4:25 AM and R1 was sleeping in his bed. V9 continued to say around 4:55 AM, V9 was on the opposite side of the unit where R1 resided. V9 said she was returning to the nurse's station and heard the exit door alarm sounding. V9 continued to say she did not hear the alarm until she was closer to the nurse's station. V9 said she was unsure how long the alarm was sounding for. V9 said emergency services dispatch called the facility and told V9 that R1 was across the street at the gas station.

On December 12, 2022, at 9:40 AM, V10 (CNA) said she was working when R1 eloped from the

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facility. V10 continued to say she was providing care to a resident on the opposite side of the unit from where R1 resided. V10 said she did not hear the door exit alarm when R1 eloped from the facility. V10 continued to say emergency services dispatch called the facility and asked if the facility had a resident named [R1]. V10 said her and another facility staff member went to the gas station where R1 had eloped to and when V10 arrived, R1 was receiving care by emergency services inside of an ambulance.

On December 9, 2022, at 1:07 PM, V11 (Fireman) said he was working on December 8, 2022, and responded to the gas station where R1 was found. V11 continued to say eye witnesses at the gas station said R1 was at the gas station for about an hour. V11 said when emergency services arrived at the gas station it was cold outside and R1 was very cold, requiring blankets to help warm him. V11 continued to say the street R1 crossed is a busy street and R1 had to cross six lanes to get to the gas station.

On December 9, 2022, at 12:32 PM, R1 was standing near the elevator on the third floor of the facility. R1 said "Why would I leave the facility to get a soda when I can just go in the basement?"

On December 9, 2022 at 1:30 PM, V7 (CNA) was completing documentation in the facility's elopement risk binder. V7 said the monitoring is for fall risk residents. V7 continued to say he completes hourly observations for residents at risk for falls.

On December 9, 2022, at 10:54 AM, exit door alarms were checked with V3 (Building Director). The alarm on the exit door stops alarming once the door is closed. V3 said the alarm on the exit

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door stops once the door is closed, but there is a separate alarm at the nurse's station that sounds. V3 continued to say that staff can reset the door exit alarm at the nurse's station.

Facility documentation titled "Post Occurrence Documentation" dated December 9, 2022, at 11:30 PM, by V2 showed, "Report was received from [local] police that resident was noted lying on the ground from a gasoline station ..."

2. The EMR showed R2 was admitted to the facility on February 18, 2019, with multiple diagnoses including: chronic kidney disease, malnutrition, and dementia.

R2's MDS dated October 11, 2022, showed R2 had moderate cognitive impairment and required supervision for locomotion off the unit.

R2's elopement care plan dated September 6, 2022, showed, "[R2] can be considered an elopement risk related to current cognitive status." The care plan continued to show multiple interventions dated September 7 2022, including "Will be on 30 minute monitoring."

On December 9, 2022, V2 (DON) said nurses and CNAs are to complete the 30 minute observation tool located in the Elopement Binder. V2 continued to say the purpose of the 30 minute observation is for residents at risk for elopement, and staff should be documenting the location of the resident every 30 minutes.

On December 9, 2022, at 11:59 AM, V1 (Administrator) provided copies of the 30 minute observation tools from the elopement binder for the dates of December 8, 2022 and December 9, 2022.

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S9999	Continued From page 6 On December 9, 2022, at 12:30 PM, V2 provided the 30 minute observation tools from October 13, 2022 to December 6, 2022. The facility did not have documentation to show R2's 30 minute observations were completed on December 8, 2022, from 12:00 AM to 5:30 AM and from 3:30 PM to 10:30 PM. 3. The EMR showed R3 was admitted to the facility on July 17, 2014, with multiple diagnoses including: heart failure, pacemaker, and cerebrovascular disease. R3's MDS dated November 3, 2022, showed R3 had moderate cognitive impairment and required supervision for locomotion on and off the unit. R3's elopement care plan revised on September 2, 2022, showed "[R3] is noted to have short term memory deficits. Resident can be considered an elopement risk related to current cognitive status." The care plan continued to show multiple interventions including the following intervention dated September 7, 2022, "Will be on 30 minute monitoring." The facility does not have documentation to show R3's 30 minute observations were completed on December 5, 2022, from 3:30 PM to 11:30 PM and December 6, 2022 from 3:30 PM to 10:30 PM. 4. The EMR showed R4 was admitted to the facility on November 13, 2021, with multiple diagnoses including Alzheimer's disease and dementia. R4's MDS dated November 24, 2022, showed R4	S9999		

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S9999	Continued From page 7 had severe cognitive impairment and required supervision from facility staff for locomotion on and off the unit. R4's elopement care plan dated September 6, 2022, "[R4] can be considered an elopement risk related to current cognitive status." The care plan continued to show the following intervention dated December 7, 2022, "Will be on 30 minute monitoring." On December 12, 2022, at 3:13 PM, R4 was standing in the hallway and said an old woman is walking around wanting to take his hair. R4 was able to ambulate independently into his room. The facility does not have documentation to show R4's 30 minute observations were completed on December 5, 2022, from 3:30 PM to 11:30 PM and December 6, 2022 from 3:30 PM to 10:30 PM. 5. The EMR showed R5 was admitted to the facility on February 24, 2021, with multiple diagnoses including Parkinson's disease, alcohol dependence, and psychosis. R5's MDS dated November 22, 2022, showed R5 had moderate cognitive impairment and required supervision from facility staff for locomotion on and off the unit. The MDS continued to show R5 was steady at all times when walking. R5's elopement care plan revised on December 12, 2022, showed, "[R5] is at risk for impaired mobility with diagnosis of Parkinson's disease or other movement disorder. [R5] is at risk for elopement due to diagnosis of Parkinson's with impaired cognition." The care plan continued to show the following intervention dated, December	S9999		

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S9999	Continued From page 8 12, 2022, "Complete 30 minute checks." On December 9, 2022, at 10:47 AM, the facility provided an undated list entitled "At Risk of Elopement." R5 was included on the "At Risk of Elopement" list. On December 9, 2022, at 1:01 PM, V2 said staff are to complete the 30 minute observation tool for the residents on the "At Risk of Elopement" list. The facility does not have documentation to show R5 had 30 minute observations prior to December 9, 2022. The facility policy titled, "EXIT SEEKING/ELOPEMENT VS. AN UNPLANNED DISCHARGE POLICY AND PROCEDURE," revised on "11/2017" showed, "POLICY: Staff of [facility] will strive to respect the independence and dignity of all residents, as well as their right to self-determination by honoring all requests to be discharged, as most residents are voluntarily admitted to the facility. This will be done in a manner that also respects the facility's legal responsibility as well as the responsibility to maintain resident safety. An unplanned discharge incident is classified as a resident who is alert, oriented to at least three, is his/her own decision-maker, is not an immediate threat to him/herself or others and is making the decision to leave the facility. This includes not returning to the facility while out on pass and/or not returning from day program/community appointments without a proper discharge order. An exit seeking attempt/elopement incident is classified as a resident who is not alert, not oriented to at least thee, has a resident representative and/or is an immediate threat to him/herself or others and attempts/is successful in fleeing from the facility.	S9999		

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S9999	Continued From page 9 PROCEDURE: ... For an Elopement: Any resident who leaves under the following conditions will be considered to have eloped, and all elopement procedures will be followed: Resident is not considered to be alert and/or oriented times three. Resident has a legal/state guardian, Healthcare Surrogate, or active Power of Attorney and leaves without the permission of the responsible party. Resident is deemed to be an immediate risk to him/herself or others (e.g., suicidal, homicidal, etc.). Resident has been assessed at admission, quarterly, annually and episodically for elopement risk and is currently assessed as being 'At-Risk' for elopement ... If a resident is evaluated at being 'At-Risk' for elopement, the following procedures will be implemented: 1. The resident's picture will be taken and provided to the nursing station of the unit the resident resides on and to the front office for monitoring of the front door to the facility. 2. Increased monitoring will be initiated if there is a change in condition for an elevated concern of elopement. 3. The resident will be re-assessed quarterly and/or as needed to continue monitoring the resident's behavior as it relates to elopement risk." (A)	S9999		