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	IL6005193	A. BUILDING: _____ B. WING _____	C 09/09/2024

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ALDEN LAKELAND REHAB & HCC	820 WEST LAWRENCE CHICAGO, IL 60640

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S 000	Initial Comments Complaint Investigation 2486442/IL176710 2486462/IL176757	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210d)6) 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 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	S9999		

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S9999	Continued From page 1	S9999		

nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Failures require two deficient practice statements.

1) Based on interview and record review the facility failed to ensure that a resident (R2) who has a community pass with supervision did not leave the facility unsupervised. As a result, R2 left the facility unsupervised on 08/05/24, boarded a bus and ended up over 35 miles away. R2 was unable to return without assistance from emergency services. R2 did not return to the facility until 08/06/24. This failure put R2 at risk for serious harm.

Findings include:

R2 is a 53-year-old resident with diagnosis that includes Acute respiratory failure with hypoxia, Asthma, Type 2 diabetes mellitus without complications, abnormalities of gait and mobility, weakness, major depressive disorder, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease or unspecified chronic kidney disease, and long-term use of anticoagulants.

On 08/20/24 at 12:24pm, R2 stated that. I (R2) am very intelligent, and I don't think I should have any problem in going out. I (R2) explained to the nurse that I (R2) want to walk out to (local store) few blocks away (from the facility) to buy some things from there. As I (R2) was walking, I became tired and weak, so I decided to get into a bus. Mind you I have not gone in a bus in 34 to 35 years. So, I thought the bus will stop at the (local

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S9999	Continued From page 2	S9999		

store), the next thing I knew the bus was in downtown heading south. I tried calling the facility and my phone was having problem in connecting. I asked for help no one was willing to help me. I was told to change my bus because the bus was not going to turn back and take me back north to (Local store). I tried calling here (referring to the facility), no one was picking up that understand what I was saying. I (R2) have a delayed speech. I (R2) started having headache from all this stress and anxious. When I (R2) got into the next bus, the next thing I (R2) know, I was on 95th street among thugs. Sorry for my language. but I (R2) was scared. I (R2) saw the police already at the bus station and when I asked for help to get back to the facility, they told me they are not a (public transportation company) don't take people and drop them off everywhere, so they called the ambulance, and I (R2) found myself at a (Local Hospital). By the time we got to the hospital my phone started working and I (R2) was able to call the (facility). The hospital arranged for the ambulance to drive me (R2) home (Facility).

R2's medical record showed physician order with order date 04/15/24 and revised date of 04/16/24 that documented that R2 may go out on pass with meds (medication) and instruction PRN (As needed) accompanied. This order was not followed. R2 has an order for oxygen per nasal cannula @ 3 liters per minute continuous every shift with order date 04/15/24 and starting date of 04/06/24. R2's medical record and pass record did not have any documentation that any medication including oxygen was made available for R2 when out on pass. R2's medical record MDS (Minimum Data Set) used in assessing facility resident dated 06/05/24 scored R2 BIMS (Brief Interview for Mental Status) at 14 indicating that R2 is not cognitively impaired. R2's medical

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S9999	Continued From page 3	S9999		

record Social Service Quarterly Assessment dated 03/06/2024 documented under progress note that R2 displays some periods of forgetfulness during which time, cues/guidance, or reorientation beneficial.

On 08/20/24 at 1:03pm, V11 (Social Services Designee) stated that in his professional opinion R2 should have oxygen supplement when leaving the facility. R2 should not go out without supervision because of R2's health being not stable.

On 08/20/24 at 2:17pm, V5 RN (Registered Nurse) stated that she did not know R2 that well. R2 asked for a pass to go out to shop, I (V5) asked V3 ADON (Assistant director of Nurse's), and he (V3) asked me to check the doctors order and when I (V5) checked there was a pass order that R2 can go out, so I gave R2 a pass for two hours to go to the store to shop without knowing R2's baseline. I (V5) took the vital signs, and they were normal. Later when R2 did not return in two hours to the (facility), I (V5) called V4 (Resident care manager/ADON) to let her know that R2 did not return in two hours. When surveyor asked about the facility protocol on pass, V5 stated to check the orders to make sure of the pass order, assess the resident and notify the management, the DON (Director of Nurse's), ADON, and the supervisor. V5 stated to be honest with you, I (V5) did not see the order that R2 should go out accompanied. The surveyor then asked V5 whether in her own professional opinion it is appropriate for R2 to go out to the community on pass without supervision (alone). V5 stated, I (V5) did not know R2 well and thinking about it, R2 should not go out without supervision because of other health issues like having respiratory issues and use of oxygen.

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S9999	Continued From page 4	S9999		

08/20/24 at 3:20pm, interview with V3 ADON (Assistant Director of Nurses), V3 stated that R2 is not able to go out on pass without supervision/by herself because R2 uses oxygen and has anxiety problem. The nurses issue the passes, but they must check the order to make sure the order documents whether the resident should go out on accompanied or unaccompanied pass. V3 was asked should R2 should go out without supervision, V3 stated, R2 is alert to make some decisions but R2 tends to have anxiety. With this issue of anxiety, I would think (R2) would be at risk to be by herself in the community without supervision.

On 08/28/24 at 9:43am, V16 NP (Nurse Practitioner) stated that R2 is not allowed to go out alone. R2 should either be accompanied by staff or family member for R2's safety. V16 stated R2 is on oxygen and when (R2) gets anxious R2 needs the oxygen. I'm worried about R2 being anxious but when she is accompanied there is someone to help. Physical limitations and being anxious is why I (V16) rarely give passes for residents to go out without supervision.

On 08/28/24 at 11:38am, V2 DON (Director of Nurse's) stated that R2's plan of care was not reviewed or changed because R2 did not have an order to go out on pass alone. V2 stated the only thing the resident must do when going out on pass is to give the receptionist the pass paper signed by the Nurse who must have verified the order making sure the order was written and followed as written.

R2's pass documentation titled "Release of Responsibility for Leave of Absence" showed person signing resident out was said resident,

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S9999	Continued From page 5	S9999		

R2. V2 (DON) stated because I was not here (Facility) at the time it happened. I could not tell you who signed it, but I think the nurse signed it.

On 08/28/24 between 1:31 to 1:35pm, interview conducted with V18 (Business office Manager). V18 stated that she was the staff covering as the receptionist on (08/05/24). R2 came to me around 3:30pm gave me a pass and said she will be right back, and the pass says to return at 5:30pm. V18 stated that at about 7pm, V11(Social Service Designee) asked me (V18) whether R2 has returned to the facility. V11 was informed that R2 has not returned. The surveyor then asked V18 before a resident leaves the facility when on pass how do you verify the pass order. V18 stated that I should have checked the order in PCC (Point Click Care) and that's something I did not do. I was thinking the Nurse has signed the pass, so I did not check PCC.

R2's hospital ED (emergency department) report documented date and time of admission as 08/06/24 4:56am and means of arrival as local fire department. R2 was discharged via local ambulance to the facility on 08/06/24 at 5:33am. R2's diagnosis listed as wellness examination.

The facility Pass procedure presented as the facility policy documented under procedure that the resident or responsible party is to sign the form indicating the date and time the resident is leaving the facility and the date and time resident is expected to return. This procedure was not followed.

The facility Medication Administration policy presented dated 09/2020 documented that medications will be administered in accordance with the established policies and procedures.

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S9999	Continued From page 6	S9999		

Procedure listed includes but not limited to drugs must be administered in accordance with the written orders of the attending physician.

2) Failed to ensure that the residents' environment remains free from accidental hazards by not leaving medication in a medication cup and a disposable razor on the bed side table for two residents (R4 and R9); failed to ensure that the treatment cart was locked when not in use and not in the proximity of the nurse to prevent tampering and accidental hazard. This failure affected R4 whose medication was left in a medication cup on the bed side table, visible from the hallway, and R9 who has a disposable razor blade stored on the bed side table. This failure also has the potential to affect all residents on the 3rd floor.

Findings include:

On 08/20/24 at 10:53am, treatment cart observed in the hallway unlocked and not in view of the nurse. When this was shown to V9 LPN (Licensed Practical Nurse). V9 stated that it is the treatment cart, and it should be locked when not in use and that because the treatment is done by the wound care nurses, she (V9) did not pay any attention to the cart being unlocked.

On 08/20/24 at 11:39am, R9 was noted in the room on the bed with two disposable razors on the bed side table uncontained. R9 stated the disposable razor belongs to (R9) and they are kept on the table. At 11:45am this observation was shown to V6 RN (Registered Nurse). V6 was asked about the facility policy / protocol on sharp objects that includes disposable Razor blades. V6 stated that sharp objects are not allowed to be kept in the rooms by residents. V6 stated when

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S9999	Continued From page 7	S9999		

not in use they are to be kept in the locked clean utility room. V7 CNA (Certified Nurse Assistant) assigned to R9 stated that R9 is not supposed to have the razor in the room. V7 stated the family probably brought it for R9.

On 08/20/24 at 11:50 am, R4 was observed in bed with eyes closed and from the hallway, a medication cup was noted on the bed side table. Upon entering the room, R4 appeared to be asleep, and the medication cup contained three pills. At 11:53am when this was shown to V6 RN (Registered Nurse), V6 identified the pills as R4's medication that R4 was supposed to have taken at 9:00am. Metformin, Meclizine and Florastor capsule. V6 stated I forgot to go back to make sure R4 has taken the medicine. When asked about the facility policy/protocol on medication administration and professional standards of medication administration, V6 stated never leave medication at the bedside, medication should be given as ordered because it can be a medication error if not taken at the right time. Anyone, the staff, or visitors can go in the room and take it. V6 stated professional standards about medication administration, I should have watched R4 take the medication before leaving the room.

On 08/21/24 at 12:10pm, one can of a disinfectant was noted in R2's room beside the bed. R2 stated the disinfectant was for (R2) and uses it to eliminate the bad odor in the room. R2's admission diagnosis includes but not limited to, Acute respiratory failure with hypoxia and Asthma. At 12:15pm. V15 (LPN) was made aware of this observation. V15 was asked about the facility policy on hazard and supervision on use of disinfectant. V15 stated that I don't know the policy and don't know whether R2 should be allowed to keep it in the room. V15 stated all I

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S9999	Continued From page 8	S9999		

know is R2 is a germophobe. At 12:27pm, V7 (CNA) assigned to R2 stated I was in the room this morning and I did not see the disinfectant can. V7 stated the residents are not allowed to keep the spray in their rooms. At 12:30pm, V12 (Housekeeping Manager) stated the facility do not allow residents to have disinfectant in their possession.

The facility Medication Administration policy dated 09/2020 documented that medications will be administered in accordance with the established policies and procedures. Procedure listed includes but not limited to, drugs must be administered in accordance with the written orders of the attending physician.

The facility Housekeeping Policy and Procedure presented with revision date 1/23 documented listed procedures that includes but not limited to all chemicals will be kept inaccessible to residents at all times. Chemicals will be stored in locked carts, cabinets, or rooms. During use chemicals will be under constant supervision of staff.

The facility Pharmacy Standard Operation policies and procedure on Medication Administration general guidelines documented that the policy is to ensure that medication is administered safely as prescribed. Residents are permitted to self -administer medications when specifically authorized by the physician and if determined able in accordance with policies and procedures for self-administration of medication. Listed procedure includes but not limited to medications are prepared and administered by the same authorized staff, administration should occur at the time of preparation.

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S9999	Continued From page 9 The facility Pharmacy Standard Operation policies and procedure on Medication Pass Guidelines dated 09/2022 documented under Locking Carts/ key that do not leave cart(s) unlocked when unattended, lock cart when not in direct view. This guideline was not followed. (B)	S9999		