STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014922	A. BUILDING: _____ B. WING _____	C 09/21/2024

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ALDEN ESTATES OF ORLAND PARK	16450 SOUTH 97TH AVENUE ORLAND PARK, IL 60467

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S 000	Initial Comments Complaint Investigation 2477336/IL177934	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)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 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological 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	S9999		

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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.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement safety measures for residents at risk for wandering, to prevent a cognitively impaired resident from eloping from a locked unit and exiting the facility without supervision on two separate occasions.

This failure resulted in R1 eloping from the facility without staff knowledge or supervision, walking past a pond and across a thoroughfare to a movie theater parking lot where R1 remained for an hour. R1 eloped from the facility a second time in the afternoon six days later when she walked past the receptionist and into the parking lot.

This failure effects 1 of 5 residents (R1) reviewed for elopement risk in the sample of 8.

Findings include:

1. On 9/13/2024 at 10:45 AM, R1 was in her bed on the locked dementia unit with the head of her bed elevated. R1 was asked a few questions to which she provided short answers or shook her head yes or no. R1 was asked if she

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remembered leaving the facility and being at the movie theater parking lot and she shook her head "no;" R1 shook her head "no" when asked if she knew the name of the facility; and R1 answered she had been at the facility for 15 days (R1's Face Sheet showed she was admitted 4/15/2024, five months earlier) when she was asked. R1 answered "no" when asked if she knew where she lived before, and stated she was not sure what town her daughter lived in. R1 answered she "doesn't know" if she had ever left the facility unsupervised before. R1 answered "yes" to using the elevator before, but "wasn't sure" of how she got there, or where she was going. R1 responded slowly to questions and her voice was very quiet. R1's Face Sheet showed her diagnoses include moderate vascular dementia, unspecified psychosis, and major depressive disorder, single episode, severe with psychotic features.

On 9/13/2024 at 12:15 PM, V1 (Administrator) showed and explained facility video covering R1 leaving the facility unattended on 9/4/2024. V1 stated video was timestamped as 8:03 PM when R1 was noted descending the concrete stairs in front of the building and then walking off to the right, out of the frame. V1 stated the facility received a call from the movie theater at 9:11 PM (over an hour later) that R1 was in their parking lot. V1 stated R1 was gone from the facility for over an hour and she did not know how R1 was able to get off the locked unit.

On 9/13/2024 at 2:00 PM, V7 (Operations Manager at local movie theater) showed the theater's security video from the evening of 9/4/2024, explaining it as it was viewed. V7 stated R1 is first seen on camera at 8:17 PM (14 minutes after leaving the facility). V7 stated there was one car parked behind a tree in the north

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parking lot and R1 walked up to it and waited. At 9:03 PM (45 minutes after R1 coming into view), two movie patrons exited the theater and went to their car and found R1 waiting there. V7 explained that one patron stayed near the car and the other went back into the theater to get the manager and security. V7 stated that at 9:06 PM, security and the manager came out to talk to R1, and R1 was only able to tell them her name and that she was thirsty. V7 explained that a Police car drove by and theater staff flagged him down. V7 stated that an item R1 was carrying had the facility name on it. V7 stated a call was placed to the facility at 9:11 PM, notifying them that R1 was at the theater. V7 stated at 9:17 PM, facility staff members arrived at the theater parking lot to escort R1 back to the facility.

On 09/13/24 at 1:50 PM, Surveyor drove in a car from the facility to the movie theater. The GPS (GPS/Global Positioning System) showed if walking along the roads to the theater, the distance from the facility to the movie theater was 900 feet. There was a thoroughfare between the facility and the movie theater and a retention pond between the facility and the movie theater.

On 9/13/2024 at 12:35 PM, V13 (Therapy Director) stated she had worked directly with R1 and R1 had confusion and diminished safety awareness. V13 stated R1 had problems with task segmentation and higher-level tasks where there is more complexity and difficulty. R1's 7/22/2024 Minimum Data Set showed R1 was moderately cognitively impaired.

R1's 4/16/2024 Exit Seeking/Wandering/Elopement Risk Assessment showed R1 had the physical ability to leave unit/facility, cognitive impairment with a diagnosis

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of dementia, and history/current behavior of elopement attempts and exit-seeking. The Assessment category showed R1 was "At Risk" for elopement.

R1's 4/22/2024 Behavior/Interventions progress note showed she was "attempting to exit the stairwell doors." R1's 8/9/2024 Social Services progress note showed "Noted to be standing by elevator frequently, attempting to board elevator ..." R1's 8/15/2024 Behavior progress note showed "Noted to be standing by elevator .... she was attempting to board elevator and becoming aggressive with staff ..." R1's 8/20/2024 Behavior note showed R1 "was standing by the elevator, attempting to push button to open the door ..."

R1's 9/5/2024 Exit Seeking/Wandering/Elopement Risk Assessment (the day after R1's 9/4/2024 elopement) continued to show R1 was "At Risk" for elopement.

On 09/13/2024 at 9:34 AM, V15 (Memory Care Director) stated we are not sure how R1 was able to get out of the building. V15 stated R1 was scored as high risk for elopement when she was admitted on 04/16/24.

On 9/13/2024 at 1:15 PM, V10 (RN-Registered Nurse) stated "If people mistakenly push 3rd floor on the elevator, the elevator goes up to 3rd floor." On 9/18/2024 at 12:05 PM, V1 stated at 8:00 PM, the Receptionist is to deactivate the front door to be opened if someone tries to enter from outside, and it then alarms any time it opens at all. V1 stated the Receptionist punched out at 8:11 PM the night of 9/04/2024 and did not set the door alarm before leaving work.

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On 09/19/24 at 12:34 PM, V22 (Medical Doctor) stated he is the primary Physician for R1 while she resides in the facility. V22 stated he was aware of R1 eloping from the facility two times. V22 stated R1 has diagnoses of dementia and psychosis and R1 is not decisional due to her diagnoses.

R1's 9/8/2024 Nursing progress note showed "Resident was standing by elevator. [Certified Nursing Assistant-CNA] tried redirecting resident to room. Resident became aggressive and tried to punch CNA."

R1's 9/9/2024 Social Service note showed "Per [night shift] staff, [R1] was agitated, attempting to get onto elevator all shift, attempting ...to enter the elevator by using force to move staff out of the way ..."

On 9/13/2024 at 9:34 PM, V15 (Memory Care Director) stated that on 09/10/2024, R1 was found in the parking lot and was brought back to the unit by a staff member around 3:30 PM. V15 stated we do not know how R1 was able to get on the elevator a second time. V15 stated R1 walked past the receptionist and went outside on 9/10/2024. V15 stated our receptionist sits at the desk from 8:00 AM to 8 PM. V15 stated a resident with dementia that leaves a locked unit unsupervised could have a fall, leave the grounds where they can't be located, and put themselves in dangerous situations. V15 stated it is all staff members responsibility to make sure the residents are safe and in the building.

On 9/13/2024 at 12:30 PM, V1 (Administrator) showed and explained facility video surveillance for R1's second elopement on 09/10/24. V1 stated R1 walked out of the main entrance of the

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facility at 2:53 PM, and then leaves the video frame. V3 (Receptionist) is then seen outside the front door at 3:17 PM (24 minutes later), looking toward the parking lot. V1 explained V3 got V4 (Human Resources/Business Office Manager-HR/BOM) and V5 (Activity Aide) for help and at 3:33 PM, R1 was brought back in the facility in a wheelchair.

On 09/13/2024 at 3:50 PM, V3 (Receptionist) verified she was the receptionist on duty on 09/10/24 when R1 eloped from the facility the second time. V3 stated she was sitting at the reception desk and she did not see R1 go past her and leave. V3 stated a family member called the facility and said, "a lady was trying to get into her car and I think she's one of your residents." V3 stated she went outside and saw R1 in the parking lot. V3 stated she informed V4 (HR/BOM) that R1 was outside in the parking lot. V3 stated she did not call a "code green" for resident elopement.

On 09/13/24 at 12:55 PM, V14 (Speech Language Pathologist) stated R1 was not oriented to time and place and had moderate to severe dementia. V14 stated while R1 was receiving therapy, the sessions were cut short due to R1 always having somewhere to go.

R1's Elopement care plan (initiated 4/16/2024) showed a focus of " ...at-risk for elopement related to cognitive impairment, physical ability to leave unit/facility. She will also stand in front of the elevator, attempt to push the button." An intervention from 4/16/2024 showed "Monitor behaviors."

The facility's 3/28/2023 Elopement and Management of Missing Resident Policy defined

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S9999	Continued From page 7 elopement as " ...a dependent (cognitively impaired, non-decisional) resident leaving a facility without staff awareness and under circumstances that place the resident's health, safety, or welfare at risk." The policy further showed "2. i. The Administrator and Director of Nursing will evaluate the situation and develop a plan of action based on the individual resident..." (A)	S9999		