STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145809	A. Building B. Wing	12/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove of Northbrook,the	263 Skokie Boulevard Northbrook, IL 60062

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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46334 Based on observation, interviews, and record review, the facility failed to follow its Code Yellow (elopement) Policy regarding monitoring residents identified as at risk for elopement. This failure resulted in R1 eloping from the facility and being off grounds for an unknown amount of time before a search was started, and a Code Yellow was called. All 15 residents being monitored for risk of elopement can be affected by this failure. The Immediate Jeopardy began on 10/23/2024 when R1 eloped from the facility, and the door alarm was canceled by the staff without initiating the code yellow protocol. V1 (Administrator) and V2 (Director of Operations) were notified on 12/02/2024 at 3:45 PM of the Immediate Jeopardy. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 12/03/24, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: R1 is a [AGE] year old female admitted to the facility on [DATE]. Diagnosis includes: chronic multifocal osteomyelitis, multiple sites; mild cognitive impairment of uncertain or unknown etiology; gangrene, not elsewhere classified; adult failure to thrive; tachycardia, unspecified; hypotension, unspecified; hypothermia, not associated with low environmental temperature; osteomyelitis,unspecified; schizophrenia, unspecified; hypocalcemia; anemia, unspecified; unspecified severe protein-calorie malnutrition; unvaccinated for covid-19; personal history of covid-19; and patient'snoncompliance with other medical treatment and regimen for other reason. R1's MDS Section C Brief Interview for Mental Status (BIMS) score is 15 (intact cognition). R1's BIMS on 11/07/2024 is 99 (interview incomplete as R1 chose not to interview). R1's care plan states R1 is a DNR (Do Not Resuscitate) and has poor decision-making skills and poor judgment. She has been homeless for the past 2 years and was found to be unable to care for herself. She has a court appointed guardian that is in contact with R1 and facility. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility sits in the parking lot of an outdoor mall, and is bordered on three sides by retail outlets and the main entrance faces a major expressway (which has a chain link fence barrier and road shoulder and landscaping before the expressway) making it inaccessible to anyone not physically fit to scale the fence and access the expressway. The facility is corralled on three sides by a privacy fence, so anyone leaving from the B doorway would be forced to walk around the fence in front of an external security camera before being able to make it to the bus stops on a busy street (which is about a 5-10 minute walk for an otherwise healthy person). The facility exit doors all have alarm monitors on them, and are all near a nursing station. There is a keypad on the wall next to the door to deactivate the alarm, or for the staff to disable the alarm prior to exiting and entering the door without setting off the alarm. Each nursing station and Reception desk was verified to have an elopement/Code yellow book in the nursing station. In addition to the protocol, there was a list of elopement risk residents that were posted in each nursing station. During the time of observation, the B nursing station was not occupied. Also, line-of-sight to the doors is not always available, so the alarm is the primary warning system. The door alarm did sound (when activated by staff activity) during survey, and was only audible within a few feet of the door. Many staff also reported they could not hear the door alarms from other areas of the building when they are not nearby. Record review and interviews revealed the Receptionist is the primary person to monitor the security cameras for the facility. The receptionist also controls the main door for visitors and answers phone calls. The monitoring of the alarm and camera is just one of the responsibilities of the Receptionist, and the desk is monitored by different people on a part-time basis during the week. On 11/29/24 at 12:40PM, V8, Wound Care Nurse, stated when R1 was first admitted to the facility, she had gangrene to her toes related to frostbite, and was in a lot of pain. R1's wounds were debrided and eventually she was able to move fast without pain, but she still received daily wound care. V8 stated R1 did not want to go to orthopedic appointments, and she was also recommended for surgery. R1 did have the necrotic skin removed, and she always slept in a chair. R1 would also wear the shoes of her choice instead of surgical shoes. R1 would also refuse treatment from time to time; this was reported to the guardian for R1 and R1's physician. R1 was seen by the Wound Care Nurse on the morning before she left. V8 could not remember the exact time he saw her on that day. On 11/30/2024 at 2:00PM, V15, Restorative aide, stated V15 was downstairs on the day R1 eloped and she was exercising downstairs with a group of residents. When she came upstairs to assist with lunch with the other residents, that is when V15 found out about the Code Yellow. She did not hear the alarm because of the television that was playing in her group. V15 stated she saw R1 earlier in the day before breakfast, and confirmed her (electronic monitoring) device was working, V15 stated when she is with a group, she cannot leave the group that she is working with to respond to the door alarms. V15 stated leaving her group could compromise the safety of the group. V15 verbalized she was able to join the group in the parking lot later and searched the retail stores for R1. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/29/24 at 2:30PM, V11, Certified Nursing Assistant/CNA, stated she saw R1 around 9:00AM on 11/23/24, and then about 5 minutes after that. R1 was on V11's case load that day. V11 remembers a Code Yellow was called around lunch time. V11 verbalized R1 did not need any assistance with her AM routine, so she only saw her briefly, and then would have checked on her again within the next two hours. When asked if two hours had passed since the last time she had seen R1, V11 could not remember. V11 stated she let the LPN (Licensed Practical Nurse) (V5) on the central unit know prior to her going on break, but did not recall hearing the door alarm. V11 could only remember R1 was noticed to be missing based on her lunch tray was untouched around lunchtime. V11 knew the Code yellow protocol and to do a head count during a Code Yellow. On 11/29/24 at 11:30AM, V5, LPN, stated V5 was the nurse on duty during the elopement. V5 said there were a lot of alarms going off that day. There were deliveries and staff entering and leaving that day. V5 also stated even though the nursing station is right in front of the exit that R1 left from, V5 was down the hall passing meds to the other residents that she was assigned to, so she did not hear the alarm sounding. V5 knew where the high risk for elopement log for residents on that side of the building. V5 also knew where the names of the high risk residents were posted. V5 knew the Code Yellow protocol, including conducting the head count. On 11/29/24 at 2:35PM, V5 added R1 does not have scheduled AM meds; her AM meds are only PRN, so she would not have a time on when she would have seen R1 without passing meds to her. On 11/29/2024 at 1:41PM, V9,CNA, stated he has been a CNA for about a year, and he normally works on the D station and was doing patient care on the day R1 eloped. V9 stated he was looking for a mechanical lift and there was one in the hall near the central exit. V9 apologetically said he heard the alarm when he got the mechanical lift from the hall, and he just turned off the alarm without checking to see if anyone left, or notifying anyone about the alarm. V9 stated he was in a rush to get back to his patient with the lift. V9 verbalized he just looked at the door and made a mistake, and feels really bad about it. V9 stated he did not open the door to check out what was going on the outside; he was going through the building looking for someone to assist with the transfer. V9 stated he cannot remember if there was anyone in the B nursing station at the time, but he found his supervisor, V10, to assist with the transfer, however, he still did not report to V10 the door alarm was sounding. V9 said V10, CNA, later discovered R1 was missing after lunch. V9 did not see R1 prior to her leaving the facility. V9 is familiar with the Code Yellow procedure and has since been in-serviced on what to do. On 11/29/2024 at 2:10PM, V10,CNA, stated she went to the bedroom of R1 on the day that she eloped and noticed her breakfast tray was not touched. V10 and her staff then started a search for R1. V10 was not sure about the time, she just knew it was about lunch time, as R1's breakfast tray was delivered to her room. R1 always eats in her room and the tray was untouched. After the search, it was determined she was not in the facility, V10 and some other staff started a search of the stores and buildings in the parking lot around the facility. V10 also got into her car and went to Chicago and started checking homeless areas. V10 verbalized she went to the city and started pulling back the blanket of homeless people sleeping on the streets to check for R1. She also asked people on the streets for information about R1. V10 stated she searched until the early hours of the morning, because she wanted R1 to be safe. V10 also verbalized she was in communication with her team of co-workers during the search, but cannot say that her colleagues searched as long as her. V10 said she searched the city based on hunches that she had. V10 stated she did not hear the door alarm prior to V9 disarming it, and V10 was familiar with the Code Yellow policy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/29/2024 at 2:15PM, V16, CNA who was on duty at the time of the elopement. V16 stated she has worked at the facility for about 2 months as a CNA, on the day in question, V16 heard the door alarm, but was in a room providing care to a resident that is a total care. V16 verbalized she could not stop what she was doing and leave her resident alone. The next time she was alerted to the Code Yellow was from the overhead paging system, which was around lunchtime. V16 then began to search in the shower and around the facility. V16 stated she did go out to the lot and look around, but then came back inside to look in the bathrooms and in the facility. V16 stated she has been trained in the Code Yellow protocol. V16 did indicate she knew the procedure for Code Yellow. V16 was providing care in rooms (room numbers), which were right next to the point of exit for R1. On 11/30/2024 at 3:00PM, V18, Recptionist, stated V18 was the Receptionist on duty at the time of the elopement, and no longer works at the facility. V18 verbalized she didn't see R1 leave the facility (via the monitor), or what could have prevented her from seeing R1 leave the facility, as the equipment was functional on the day of the elopement. V18 said when the nurse silenced the alarm, she thought the situation was over. V18 verbalized she did call the Code Yellow when advised, but she was not trained on notifying of the all clear. She stated she has had in-service training, but did not have a clear understanding of the protocol. On 11/29/30 at 10:45AM, V1, Administrator, and V3, Director of Social Services, were interviewed. They discussed facility's efforts to coordinate with local and other municipal police departments, sister facilities, Chicago Transit Authority (CTA) and hospitals, in addition to facility staff members going into the communities to search for R1. V1 described the Code Yellow policy, and how the protocol should have worked. V1 and V3 also described how they started to in-service staff on proper execution of the policy. as well as revisions made to the Code Yellow policy. V1 also stated he was able to view the video of R1 leaving the facility through the door of station B. V1 was able to describe the clothing R1 was wearing, and that she had taken her belongings in two bags attached to her rolling walker. The video was not saved, and was erased by the camera system looping over the video. V3 was able to provide care plans and other documents related to facility policies. V3 also stated she is keeping a log of the efforts to return R1 to the facility. V3 did not share the log, and provided verbal information on progress towards R1's return to the facility. V1 also stated the door alarms are tested daily by the Maintenance Director. On 11/29/2024, V1, Administrator, V4, Activities Director, V6, Registered Nurse/RN, V7, CNA, V12, CNA, V13, RN, V14, Social Serivces, and V17, Part-time Receptionist, and all knew the protocol for Code Yellow and how to activate the head count. All workers also verbalized being recently in-serviced on the Code Yellow protocol. On 11/30/2024 at 12:05PM, V2 (VP of Operations) stated he was informed of the elopement around 1:30PM/2:00PM. V2 stated he was able to contact the CTA (Chicago Transit Authority) via the local police, and was able to determine R1 was near a sister facility and sent worker(s) to CTA facility to retrieve her, but was too late when they got there. It was determined by the CTA that R1 had gone into Chicago. V2 confirmed his team has searched known areas for R1 and homeless people to gather, and maintained contact with hospitals daily. On 12/01/2024 at 10:00AM, reviewed facility Code Yellow plan, dated 11/01/16 and revised 07/26/24, which reads: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When the door alarm sounds, staff members shall immediately respond to determine the cause of the alarm; A) The staff member responding to the alarm shall check the outside/vicinity of the area to determine if a resident has exited the building. B) If upon investigation no reason can be found for the sounding of the alarm the Administrator/DON/designee must be notified. C) A head count will be completed on all units and completed accounting of all residents given to the administrator/DON The Immediate Jeopardy that began on 11/23/24, was removed on 12/03/24, when the facility took the following actions to remove the immediacy: 1.) Facility staff immediately called a Code Yellow on 11/23/24 at 1:00PM, when facility determined that resident was missing. Staff conducted a search inside the facility including outside of facility premises. 2.) A Police Report was immediately filed for a missing resident, R1, on 11/23/24 at 1:15PM to Officer (name, badge#) of the (city) Police Department. 3.) On 11/23/24, the CNA who responded to the alarm door was immediately educated not to turn off the alarm until a visual check/search is completed. This training was conducted by the Asst. Administrator. 11/23/24 at 3:15PM. 4.) The Receptionist assigned was educated on 11/23/24 to make sure to look at the monitor to make sure no resident had exited, and not to turn off the alarm until a visual check/search is completed. On 11/23/24at 3:00PM Training was conducted by Assistant Administrator. The in-service included proper Alarm Response and utilization of the zone panel & camera system. Discussed appropriate times to call Code Yellow and to not cancel the alarm until given the 'all clear' following a head count. Emphasized the scope of receptionist responsibilities as the 'security station' of the facility. 5.) All employees were in serviced to ensure an immediate response to an exit door alarm is done, educated not to turn off the alarm until a visual check/search is completed. A head count is also to be completed to ensure that all residents are accounted for. If a resident is noted missing, staff to follow the facility protocol on missing residents. This was initiated on 11/23/24 and completed on 11/26/24. This in service will also be provided for every newly hired staff moving forward. 11/23/24 at 4:30PM. The training was initially conducted by Social Services and Assistant Administrator on 11/23/24 for those present. The training continued both in person and over the phone for the remaining employees over the next 3 days and was conducted by Food Services Director, CNA Supervisor, Social Services, Assistant Administrator, and Administrator. HR Manager printed out a complete facility roster which was cross-referenced to ensure all employees were educated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6.) The Maintenance Director conducted an immediate check of the facility exit alarmed doors. All exit doors are alarmed and functioning. This check was initiated on 11/23/24 and will continue checking daily. 7.) A facility wide audit to identify residents at risk for elopement, those at-risk for elopement must have photos in the elopement list posted on the bulletin board on each unit and at the reception desk for quick reference. Currently, there are 15 residents identified at risk for elopement. Audit was completed on 11/23/24 by Assistant Administrator/Social Services Director. Resident photos are taken upon admission to the facility and Elopement List is posted at each nursing station (both in a binder and on bulletin board for quick reference) and at the reception desk. Staff were in-serviced that bulletin boards will be used as the central location point in which to reference the elopement list at each nurse's station. 8.) The Social Service Department reassessed residents identified for elopement and elopement care plan was reviewed and updated. This was initiated and completed on 11/23/24 at 6:00PM by Social Services. 9.) On 11/23/24, a facility door alarm drill was conducted to ensure staff are appropriately responding to an exit alarmed door and not to turn off the alarm until a visual check /search is completed. A facility protocol was put in place to ensure a head count is conducted after the visual check/search is done to ensure all residents are accounted for. This in-service was initiated by Social Services at 5:00PM on 11/23/24. 10.) The facility has identified approximately 25 (city) & surrounding area hospitals which facility staff continue to call daily in search of R1. This began on 11/23/24 and is ongoing. 11.) On 11/30/24, (electric company) was called in to provide extra sound devices to project a more amplified sound to ensure staff can hear & respond to an alarm. (Electric company) will complete the work order on 12/1/24 to install necessary devices to address the concern. 12.) On 12/1/24, (electric company) arrived at 7:00AM and installed 7 new sound devices throughout the facility which project a more amplified sound to ensure staff better hear the door alarms. (Electric company) has also placed an order for dome lights to be installed at each exit door. This will hopefully be done by weeks end. 13.) All receptionists were in-serviced on Alarm Response and Utilization of Camera System to ensure camera is checked thoroughly before canceling the alarm system. This was completed on 12/1/2024. Receptionist separated from the facility on 11/27. Training was conducted by Assistant Administrator. The in-service included proper Alarm Response and utilization of the zone panel & camera system. Also discussed were appropriate times to call Code Yellow and to not cancel the alarm until given the 'all clear' following a head count. Lastly, we emphasized the scope of their responsibilities as representing the 'security station' of the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	14.) An additional in-service was conducted to all employees of the new amplified alarm devices to ensure staff are familiar with the amplified sound and respond immediately to the alarm. All staff were also in serviced on the purpose and locations of the zone panels should an exit alarm be sounded to determine location of alarm if uncertain. Staff were also in serviced on the location of the elopement risk residents' list that is posted on the bulletin board in every nurse's station for quick reference. This was initiated on 12/2/2024 and will be completed by end of day on 12/3/24. Training was initiated by our two Social Services Designees and our Social Services Director on 12/2/24 for those employees who were present. The training continued both in person and over the phone for the remaining employees through 12/3 and was conducted by the Food Services Director, CNA Supervisor, Social Services/Assistant Administrator, Administrator and Guest Relations. The HR Manager printed out a complete facility roster which was cross-referenced to ensure that all employees were educated. 15.) A QA (Quality Assurance) audit tool was initiated on 11/23/24 to ensure the main exit door alarm system and the (electronic monitoring) system are checked for functionality daily and documented by maintenance. This will be done daily x14 days and 3x/week x2 weeks and weekly x 8 weeks. 16.) A QA audit was initiated on 11/23/24 to ensure staff are following door alarm drill, and all residents are accounted for. This audit will be done daily x7 days and 3x/week x3 weeks and weekly x 8 weeks. 17.) The QA audit tool that was initiated on 11/23/24 was revised after the additional amplified alarms were installed by (electric company) on 12/1/24 to ensure the exit door alarm system remains amplified. This will be conducted daily x7days, 3x/weekly x 8 weeks. The QA tool revisions were made on 12/1/24 at 5:00PM 18.) A QA Audit was initiated on 12/1/24 to ensure receptionists are responding to an alarm system by initiating a 'Code Yellow' and checking the camera thoroughly before canceling the alarm system. This QA will be completed daily x 7 days and 3x/week x8 weeks. The QA audit was initiated at Approximately 11:00AM on 12/1/24. 19.) The elopement policy was reviewed and revised on 12/2/2024, which included specifying types of door alarms and defining them, as well as creating a centralized location at each nurse's station for quick reference of the elopement list. Policy was also revised to reflect the facility's specific protocols on Routine Procedure for Wandering Residents and Prevention of Missing Residents/Elopement. Training on the revised Elopement Policy was initiated by Social Services on 12/2/24 for those employees who were present. The training continued both in person and over the phone for the remaining employees through 12/3, and was conducted by the Food Services Director, CNA Supervisor, Social Services/Assistant Administrator, Administrator and Guest Relations. The HR Manager printed out a complete facility roster which was cross-referenced to ensure that all employees were educated. 20.) The QA trends will be discussed in QAPI scheduled on 12/9/24 and then monthly. 21.) The facility Medical Director was notified of the basis of abatement plan, and has approved on 12/2/24.