STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14A050	A. BUILDING _____ B. WING _____	09/09/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD MANOR, THE	**2444 WEST TOUHY AVENUE CHICAGO, IL 60645**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210 a) The facility must provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care, Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing needs and personal care needs of the resident.	F9999		

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F9999	Continued From page 9	F9999		

300.1210 b)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.

300.3100 d) 2)
All exterior doors shall be equipped with a signal that will alert staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

Based on record review, staff interview and incident report review, the facility failed to ensure that 1 resident (R8) received adequate supervision to prevent elopement from facility by an interior door which is supposed to be locked at all times.

Findings Include:

R8 is 74 years old and diagnoses include dementia and schizoaffective disorder. R8 is assessed as cognitively impaired and disoriented to person, place and time. Community skills assessment completed 01/24/03 state staff need to assist R8 with travel in community because she is unable to follow safety rules.

During record review there were documents dated 06/23/04 from the Mobile Intensive Care Unit of the Chicago Fire Department (CFD) -

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	14A050	A. BUILDING _____ B. WING _____	09/09/2004

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F9999	Continued From page 10	F9999		

Bureau of Emergency Medical Services (EMS). This report indicated that the EMS team was dispatched at 5:28a.m. and arrived at 7200 North Western Avenue. Report states R8 was found sitting on the sidewalk with small laceration to right side of temple and abrasions to right arm. Report also states R8 was confused and mumbling incoherently and unable to answer any questions. Care was initiated, electrocardiogram at scene showed rhythm as tachycardia and R8 transported to local hospital at 5:44a.m.

7200 North Western is the major intersection of Touhy and Western and is approximately 585 feet from the front door of the facility

Nurses notes dated 06/23/04 at 5:45a.m. state R 8 "noticed missing, nowhere to be found, searched all the rooms, washrooms and surroundings. R8 nowhere to be found."

The next nurses notes at 5:55a.m. state " received a call from hospital emergency room. R 8 was brought there by CFD (Chicago Fire Department) and is being evaluated at present"

At 9a.m. R8 was brought back to facility from the hospital.

Incident and accident reports had been reviewed for the year and there was no report of above incident.

E3, Director of Nurses, was interviewed on 09/08/ 04 as to this incident. E3 stated she thought R8 probably went out the front door and later after she had a discussion with E2, Assistant Administrator, told surveyor that it was thought R

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F9999	Continued From page 11	F9999		

8 went out an interior basement door and down a staircase because that door had been found not to be completely closed. This door leads to a steep 12 step staircase, to an unalarmed exterior door and out to an exterior staircase that opens to a large parking lot which fronts Touhy Avenue, a major city street.

The interior basement door is required to be kept locked at all times. E3 stated the door closing device was found not closing properly and was fixed on 06/23/04. E3 also stated a electronic device was placed on R8 on 06/23/04 because of elopement. E3 and E2 stated the unalarmed exterior basement door was probably opened because kitchen staff were arriving at facility.

Surveyor requested investigation of this incident and E3 stated there was no investigation completed.

Surveyor informed E3 there was no report of this incident. E3 presented surveyor with report and stated it had been misfiled. This report indicted R 8 left the facility without permission around 5a.m and was later found at local hospital with abrasion to rt. eyebrow. This report contains no investigation of this incident, nothing about R8 being found by the CFD and there is no evidence the Department was notified of this incident.

On 09/09/04 facility presented surveyor with an investigation of the incident of 06/23/04. This investigation contained the previously stated course of events including the closing device on the door was loose and was unable to close door completely, a sign was posted on door that warned staff they must close door completely and