STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14A057	A. BUILDING _____ B. WING _____	C 07/12/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN NURSING HOME	**5448 NORTH BROADWAY STREET CHICAGO, IL 60640**

(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 STATE VIOLATIONS ASSOICATED WITHTHIS COMPLAINT: 300.1210 a) 300.1210 b) 6) The facility must provide the 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 and personal care needs of the resident. Personal Care, as defined in section 300.330, is assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual (Section 1 -120 of the Act)	F9999		

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F9999	Continued From page 7 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. Findings include: Review of R2's resident profile face sheet, R2 was a 71-year old male with diagnosis including Dementia and Schizo-Affective disorder. Per R2 's 02-22-1999 psych evaluation R2 was assessed to be confused, incoherent and had attempted to leave the facility before. R2's 02-22-1999 electronic monitoring device assessment stated the need was based on the 02-22-1999 psych evaluation. Per R2's 06-16-05 quarterly minimum data assessment R2 was assessed moderately cognitively impaired requiring supervision. Per R2's 06-16-2005 care plan R2 was assessed to attempt to leave the facility. Per facility incident report and nurse's notes dated 06 -25-2005 R2 was reported missing at 12:30PM & was wearing an electronic monitoring device. Per 06-25-2005 nurse notes R2 was last seen in the facility by E4 (RN) at 8:30AM. Per nurse's notes and incident report on 06-25-2005 a search was conducted and R2 was never located. Per documentation the police was notified 06-25-2005 at 2:45PM, a police report was made at 4: 00PM and the guardian was notified 06-26-2005 at 9:00AM. On 07-07-05 at 3:00PM surveyor interviewed E1 (administrator), and E2 (director of nursing) and on 07-08-05 at 11AM surveyor interviewed E3 (PRSC). E3 stated on 06-25-05 she was	F9999		

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F9999	Continued From page 8 assigned to the first floor secretary duties which included monitoring the facility door alarms. During interviews with E1, E2 and E3 each individual stated the alarm sounded for the rear back door 06-25-05 at 12:30PM. E1, E2 and E3 stated at that time E3 made an announcement over the intercom "would all staff check the back door". Per E1, E2 and E3 the facility policy is that the security guard assigned to monitor the front door is also to respond to any announcement to check alarmed door as well as any staff in the area. Per surveyor interview with E7 (security) and E6 (covering for security on 06-25-05) they both stated they were unaware of who would cover the front door if security was to respond to another door alarm. Both security officers responded to the back door alarm on 6-25-05, leaving the front door without direct observation. Per interview with E1, E2, E3 and E4 (RN) an immediate search was performed around the outside of the facility. The facility proceeded to do a floor check for each resident. Per interview with E4 it was determined that R2 was unaccounted for. Per E1, E2 and E4, a police report was made and R2 never returned to the facility. On 07-07-05 at 2:00PM surveyor interviewed R1 (R2's room mate). R1 was observed by surveyor to be disoriented to person, time and place. On 07-07-05 surveyor interviewed Z2 (attending physician) and Z3 (psychiatrist) who both stated R2 had no change in mental status that they were aware of. On 07-07-05 and 07-12-05 surveyor interviewed Z1 (detective) who stated R2 was found on the commuter train track on 06-25-05. Per Z1, R2 was observed to have waited until the train approached and then jumped in front of the train.	F9999		

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F9999	Continued From page 9 Per Z1, R2 was pronounced dead on 06-25-05 at 12:35PM and the cause of death was multiple injury, train striking/suicide. Per Z1, R2 was positively identified by a label with his name in his clothing.	F9999		