STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145147	A. BUILDING _____ B. WING _____	08/01/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS - LAGRANGE / VICTORIAN MANOR	**339 SOUTH 9TH AVENUE LA GRANGE, IL 60525**

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F9999	FINAL OBSERVATIONS F324 relates to R28 who resides on the Alzheimer's Unit and is subject to Subpart U Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder	F9999		

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F9999	Continued From page 22 . These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 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. b) 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. Based on observation, interview and record review, the facility failed to supervise 1 resident of 13 residents (R28) who resides on Unit 3, the Dementia and Alzheimer's unit, and who was identified as at risk for elopement. The facility staff were unaware that R28 had left the unit and the building unsupervised and unescorted. The facility failed to: 1. Supervise 1 resident (R28) on the Alzheimer's and Dementia unit, with a known history of	F9999		

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F9999	Continued From page 23 wandering, who was identified as an elopement risk, and was known to be cognitively impaired with poor illogical decision making that required supervision and verbal cues for safety. 2. Follow the facility's elopement policy by not performing hourly checks. 3. Re-assess R28 for elopement risk. Findings include: 1. R28 is 74 year old with diagnoses including Diabetes Mellitus, Dementia with agitation, Seizure disorder and Depression. Physician's Orders dated 06/01/2005 thru 06/30/2005 note the following medications: Reminyl, Risperdal, Phenytek and Novolin Insulin. R28's MDS (Minimum Data Set), dated 03/31/ 2005 and 06/23/2005, were reviewed. R28's score for "Cognitive Skills for Daily Decision-Making" was a "2..moderately impaired-decisions poor cues/supervision required." R28 was scored as 0/0 on both MDS's for " wandering" under "Behavioral Symptoms"..." behavior not exhibited in last 7 days, behavior not present or behavior was easily altered," although R28 had previously left the unit unescorted and unsupervised on 03/29/2005. R28's care plan for Wandering/Risk of Elopement was reviewed. The following interventions were listed: "Provide supervision and oversight to ensure safety." and "Provide visual check of resident every hour." Per the facility's incident report dated 07/14/2005 the following information was noted: On 7/13/	F9999		

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F9999	Continued From page 24 2005, R28 was not on unit at dinner-time at approximately 6:00 p.m. Code Green Policy was initiated. Immediate search of unit, building and grounds began. DON and Administrator were paged and returned to the facility. Surrounding area was searched by staff members. The police were notified and a report was filed by the DON. The resident was entered into the database of missing persons by LaGrange Police Department . Intensive search of the area continued, including surrounding suburbs and local merchants. Area hospitals were contacted to be on alert for the resident. The attending physician and guardians' office were made aware of the elopement and ongoing search. On 7/14/2005, at approximately 9:35 a.m., the resident was located by facility staff and returned to the facility. A complete set of vital signs and body check were performed. Resident was not in distress and was verbally displeased that he had been found and returned to the facility. Upon R28's return to the facility, R28 was given a breakfast tray and a bath. R28's blood glucose level was checked and the resident was given insulin. All appropriate parties were notified of the resident's safe return. 2. Review of the facility's Incident/Accident Reports documents that R28 had left the unit unescorted and unsupervised through the unit's back exit door on 2 separate occasions, once on 03/29/2005 during a fire drill and again on 05/09/	F9999		

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F9999	Continued From page 25 2005. 3. E2 (Director of Nursing) was interviewed on 07/28/2005 from 1:45 p.m. to 2:00 p.m. in the 1st Floor Conference Room. E2 stated that she was notified at approximately 6:08 p.m. on 07/1/2005 that R28 was again missing from the facility and had apparently left the facility some time that day during a fire drill. 4. E27 (CNA) stated, during interview on 07/28/2005, between 3:07 p.m. and 3:17 p.m. in the 1st Floor Conference Room, that she worked 3-11 on 07/13/2005. E27 stated that staff are to do hourly checks for residents in their assigned section that are at risk for elopement. E27 further stated that she checked for R28 at the beginning of her shift and again at 4:00 p.m. and 5:00 p.m. She stated that she never saw R28 at those times but did not report him missing on the unit nurse until 6:08 p.m. when she went to get R28 to bring him to the dining room for dinner. E27 admitted that she signed her initials in the hourly check log for R28 anyway. She stated that she thought she was signing that she had checked for the resident, not that she had actually seen the resident. 5. E23 (CNA) was interviewed on 07/28/2005 between 1:10 p.m. and 1:17 p.m. at the Unit 3 Nurse's Station. She stated that the fire alarm went off sometime between 1:50 p.m. and 2:00 p.m. E23 stated that she saw R28 in his bed prior to and after the fire drill was completed. She stated that all staff on the unit are responsible for checking the entire unit for all residents at risk for elopement and then complete the log. 6. E22 (LPN) was interviewed on 07/28/2005 in	F9999		

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F9999	Continued From page 26 the 1st Floor Conference Room between 11:50 a. m. and 12:05 p.m. She stated that the fire drill began at approximately 1:45 p.m. and that she saw R28 in his bed at the beginning of the fire drill and again at approximately 2:15 p.m. when she did a head count after the fire drill was over. E22 stated all staff do hourly checks on all residents who are at risk for elopement and that staff must sign off in the log book. E22 confirmed that R28 had had 2 previous elopement attempts in 3/2005 and 5/2005. 7. E26(LPN) stated, during interview on 07/28/ 2005 between 2:39 p.m. and 2:55 p.m. in the 1st Floor Conference Room, that she worked the 3-11 shift on 07/13/2005. E26 stated all staff are responsible to do head counts when they arrive on the unit at the beginning of their shifts. She stated that one day, she arrived late to the unit and did not do a head count. 8. The facility's policy titled "Hourly Visual Checks " states: "Residents who have been identified as having a potential for elopement will have the following....Residents will have initiated and maintained the hourly checklist. This check list is to be completed by the Nursing Staff on the unit the resident is assigned, and initialed after resident has been visually seen on the unit each hour. "	F9999		