STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145329	A. BUILDING _____ B. WING _____	C 11/03/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIDGE HLTHCR & REHAB CENTRE	**7001 WEST CULLOM NORRIDGE, IL 60634**

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F9999	FINAL OBSERVATIONS	F9999		

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.

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 interviews, observations, closed record review and police report, the facility failed to provide the necessary supervision to one resident in the sample (R1) who eloped unnoticed from the facility on October 19, 2004 and was found by the police about 4 miles from

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F9999	Continued From page 8 the facility on October 22, 2004. R1 expired from Hypothermia and Cold Exposure on October 22, 2004 shortly after he was taken to the hospital. R 1 was a known identified elopement risk and left the facility without being seen or setting off the audible alarm. Findings include the following: R1 was an 80 year old male resident who was admitted to the facility on June 25, 2003 with the following diagnoses: Recurrent Syncope, Cerebral Vascular Accident, Alcohol Abuse, Arrhythmia and Gastric Ulcer. R1 was noted upon admission to be an elopement risk. The admission orders for R1 state the following: " apply elopement bracelet, check every shift and change every 90 days." R1's admission MDS (Minimum Data Set) assessment dated July 1, 2003 codes R1 as having impaired short and long term memory and moderately impaired decision making ability. R1's admission care plan dated June 26, 2003 and July 14, 2003 also identified him as being an elopement risk and contained the following interventions: "Picture posted on all floors, Bracelet alarm, test alarm bracelet every shift, Record testing of bracelet, replace bracelet every 90 days, Redirect resident from unsafe areas, observe and monitor resident's daily activities and whereabouts." R1's care plan dated June 4, 2004 and August 31, 2004 continues the same interventions for monitoring the resident and continues to assess him as an elopement risk. R1's MDS dated August 18, 2004 also continues to describe R1 as having both short and long term memory losses and impaired decision making.	F9999		

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December 1, 2003 R1 was observed out of the facility in the community and returned to the facility without any injury. R1 told staff at that time that he wanted to buy some razors. This incident was reported to the physician and the Department as required. From December 1, 2003 until the incident of October 19, 2004 the resident had no further attempts to elope from the facility.

October 19, 2004, R1 was noted by facility staff to be missing from the facility. E10 (Certified Nurse Aid) was the last staff person to see R1 in the facility. E10 stated she last saw R1 at 6:00 pm. E5 (floor nurse) noted R1 was missing around 8:00pm when E5 attempted to give R1 his evening medications. E5 notified E6 (PM Shift Nursing Supervisor) and the staff began to search for the resident. The entire unit, floor and outside area was searched and staff was unable to locate R1. E6 then notified E1 (facility Administrator) and E2 (Director of Nursing) that R 1 was missing. E6 also called the local police to assist in the search for the resident. R1 was never located and on October 22, 2004 at 3:50 pm, E1 was called by the Chicago Police Department that the resident was finally found and being transported to a local hospital. R1 was later pronounced dead at the hospital. The cause of death was listed as: "Hypothermia and Cold Exposure".

A review of the police reports confirms that the facility notified the police at 8:45pm. The police report indicates that R1 was noted in a local bar on October 19, 2004. The local police also notified the Chicago Police Department and searched R1's last known residence with no

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results. The police report and the facility had no idea where R1 was for 3 days he was missing until he was found several miles away from the facility. R1 was wearing a leather coat, hat, pants and shoes as per the police report and interviews with facility staff. Direct care staff interviewed stated that R1 "always wore his hat and leather coat". R1 was found on October 22, 2004 with his leather jacket on and dressed in pants and shirt. The alarm bracelet was intact when R1 was found.

E5 was interviewed by surveyor October 28, 2004 and stated that she checked R1's alarm bracelet as per policy when she started her shift. E5 stated that R1's alarm bracelet was working and that she attempted to find him after dinner. E 5 stated that when she could not locate R1 on the unit or on the first floor she called E6. E6 stated that it was noted that R1 was missing around 8: 00pm on October 19, 2004. E6 stated that the staff checked the unit and every floor, the outside and the nearby area and when they could not locate R1 the administrator was called along with the local police. E6 stated that the alarm system was tested and it was working. E10 (Certified Nurse Assistant [CNA]) was interviewed October 28, 2004 and stated that , "R1 always wore his leather coat and hat and I last saw him at about 6 :00pm." "I don't ever remember him leaving the unit". E10 stated that the staff looked everywhere for R1 but they never found him. E9 (afternoon receptionist) was interviewed by phone October 28, 2004. E9 stated that she knows R1 cannot leave the building and was an elopement risk. E9 stated that the alarm system only rang once during her shift and that was at 8: 00pm but it was not R1 who set off the alarm but

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another resident. E9 stated that she did not see R1 leave the facility. E9 stated, "I sit at the desk and answer the phone, I do filing and copying." "I only heard the alarm once" and "I cannot see the front door if I am copying material or filing". "He could have gotten out when I was copying ". Surveyor confirmed that the front door cannot be visualized from the reception area if the person is copying or filing.

E1 was interviewed on October 28, 2004 and November 3, 2004 about R1's elopement. E1 stated that the alarm system was working the night R1 eloped and that R1 was found in the Emergency Room (ER) with the alarm bracelet in place. E1 stated that the facility monitored the system weekly as recommended by the manufacturer and that the facility had the company out to ensure the system was functioning after the incident. (E8 [Maintenance Director] provided surveyor with copies of the facility's monitoring record). E1 stated that it was discovered during the investigation that another resident, R2, witnessed R1 leaving the facility. R 2 heard staff talking about R1 missing and reported to staff that she saw R1 leave the building. R2 reported this information on October 19, 2004 to staff and E1 then interviewed R1. E1 stated that the alarm company was finally able to diagnosis the system as having " intermittent failure". The system was adjusted by the alarm company and the facility has been testing it daily. The system was also tested by the surveyor on October 28, 2004 with E8 and was noted to work. The surveyor also tested the system again with E1 on November 3, 2004. All tests were positive and the system responded. E 1 stated, "we think the alarm failed and he went

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F9999	Continued From page 12 out the front door". Surveyor interviewed R2 October 28, 2004. R2 stated, "It was 6:30 and I saw him go out the door, the alarm never went off". R2 stated she was going to Bingo when she saw R1 leave. Surveyor confirmed that Bingo was scheduled that night on the first floor at 6:30pm. A review of R2's medical record and interviews with staff reveal that R2 has intact long and short term memory. Surveyor interviewed Z1 (attending physician) by phone November 1, 2004. Z1 stated, "he [meaning R1] had Dementia and was not safe in the community, he needed to be in a nursing home". "I cannot understand how he got out, he had the bracelet on, I don't understand". The weather in the Chicago area for October 19, 20, 21, and 22 was as follows: October 19, 2004: High Temperature 54 degrees F and Low Temperature 48 degrees F October 20, 2004: High Temperature 54 degrees F and Low Temperature 51 degrees F October 21, 2004: High Temperature 59 degrees F and Low Temperature 48 degrees F October 22, 2004: High Temperature 64 degrees F and Low Temperature 46 degrees F The facility failed to adequately supervise a known wanderer (R1)and this failure resulted in R 1 eloping from the facility and being found three days later and dying from exposure to cold weather.	F9999		