STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145171	A. BUILDING _____ B. WING _____	C 12/15/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN OAKS NRSG & REHAB CTR	**270 SKOKIE HIGHWAY NORTHBROOK, IL 60062**

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F9999	FINAL OBSERVATIONS STATE VIOLATIONS ASSOCIATED WITH THIS SURVEY: 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	F9999		

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F9999	Continued From page 8 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) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 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 staff and other interviews, review of the medical record, police report and hospital records, the facility failed to adequately monitor and supervise one resident. R3, a cognitively impaired and mentally challenged resident left the building unknown to staff on 10/03/04. R3 was last seen by staff at approximately 8:00AM on 10/3/04. R3 was found outside, by police, at approximately 9:00AM after the police received a call from a concerned citizen. R3 was not properly dressed for the weather when police found R3 in the shopping center across the street from the facility. R3 had no pass orders to leave the facility and needed to be sent for evaluation	F9999		

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F9999	Continued From page 9 to a hospital for signs of hypothermia. Findings include: Review of the police report dated 10/03/04 indicated that a complaint to do a 'well-being' check was received at 9:01 AM. The complaint concerned a male who had been observed sitting on a curb at the north end of a shopping center. Interview with Z1, one of the officers on the scene, revealed that the officers arrived within 15 minutes of receiving the call. R3 was cold and shivering, had a cut on the left side of his face, and was dressed in a sweatshirt, pants, and socks. The socks were wet and there was blood on them from his left foot. R3 had no shoes on. R3's feet were sitting in a puddle of water near the curb. The back of his sweatshirt was found to be damp to touch and the grass on the knoll where R3 was sitting "appeared flattened, as if someone had been lying on it, sleeping". R3 was unable to provide any information to the officers other than his name. The paramedics, who had responded per police report, obtained R3's oral body temperature of 92 degrees Fahrenheit (F); they placed heating pads under his armpits and between his legs, covered him up, placed him in the ambulance and transported him to the hospital. Review of Paramedic Report dated 10/03/04 indicates paramedics arrived at 9:38AM. Temperature of R3 taken en route to hospital at 9 :41AM was 94.9 degrees Fahrenheit. R3's medical status, described per this report, included that R3's skin was cool/cold, skin color was pale/ashen, dry and that R3 was verbal and confused during transport. R3 arrived at the hospital at 10:00AM.	F9999		

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F9999	Continued From page 10 Review of Hospital records indicate that R3 was admitted to the Emergency department with a diagnosis of Hypothermia. Emergency notes indicate R3's status upon arrival as" hypothermic, was awake, had an abrasion which appeared to be old of the left upper eyelid and left cheek area ". Temperatures documented at 10:26AM, rectally 96.9 degrees Fahrenheit, 10:30AM orally 96.1 degrees Fahrenheit, 11:30AM orally 96.8 degrees Fahrenheit, 12:30AM orally 97.3 degrees Fahrenheit, and at 1:19PM an oral temperature 97.6 degrees Fahrenheit. R3 was treated, re-warmed and returned to the Nursing home in good condition. The shopping center where R3 was found is located across the street from the nursing facility. This street was a 4-lane highway with a posted average speed limit of 35 miles per hour. The outside temperature ranges according to O¿Hare Preliminary Climate Data report for 10/03/04 were as follows: Minimum 36 degrees Fahrenheit to a maximum of 70 degrees Fahrenheit, with an average of 53 degrees Fahrenheit. Review of R3's medical record indicates his date of birth as 3/3/61. This medical record denotes several diagnoses including: Borderline mental retardation, Bi-polar affective disorder, stammering and stuttering and cardiac dysrrhythmia. R3's comprehensive assessment tool, dated 8/28/04, codes R3's cognitive level as (2)--moderately impaired; decisions poor; cues; supervision required. R3's memory recall ability indicates only his ability to locate his own room. Review of R3's level of functioning assessment dated 07/12/04 identifies his use of community resources as totally dependant for the ability to use public transportation; to travel to and from	F9999		

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F9999	Continued From page 11	F9999		

residence; his ability to recognize and avoid common dangers as totally dependant. Review of R3's Elopement Risk Assessment dated 7/17/03, admission, to the most recent, on 4/23/04, quarterly review document reflects "no to attempts to elope (unauthorized leave) from the facility."
Review of 10/03/04, 3:10AM, nurse's note denotes that R3 "came out from room; appeared to be pleasant and conversant; asked for a glass of orange juice and cookies; given and encouraged to go to bed and get some sleep; resident followed, slept at short intervals."
Interview with unit 2 west, 11PM-to 7AM nurse on duty for 10/03/04, E4 Assistant Director of Nurses (2), confirmed this documentation. E4 revealed that when he arrives for duty he will make rounds, room to room, to make sure that the number of residents is as census. The night in question all the residents were accounted for. E4 also revealed that he had seen R3 at around 6:00 AM while doing accu-checks in a nearby room and he saw R3 in bed. E4 also recalled that when he had finished his tasks, it was around 6:45AM, when he was back at the nurses station and R3 was still in his room.
Review of 10/03/04, 7:45AM, notes show R3 " noted in room still eating breakfast", these notes were signed by E3 ADON (1), Supervisor.
The next nurse's note for 10/03/04, at 9:00AM, indicates that R3 was not on the unit and a search had been initiated. The following nurse's documentation, on 10/03/04 at 9:30AM indicates that the facility received a call from the police department just as the facility was about to notify them of the missing resident.
Interview with E7 (unit nurse on 10/3/04) revealed that she had not seen R3 when she had

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F9999	Continued From page 12 first come in at around 7:00AM. E7 revealed that the first time she was aware of R3 being missing was when she was passing medications. E7 revealed she had started her medication pass at around 7:30AM. And that she had first discovered R3 was missing, about 9:00AM, when she had gone to his room to give him his medications. E7 said R3's breakfast tray was in his room and it "looked as if it had not been touched. " E7 said she then notified E3 that R3 was missing. E7 further revealed that when she had noted that R3 was missing she had directed staff to search for R3 in the other rooms, the dining room, and the smoking room on 2 East. E 7 revealed that she had asked the CNAs if they had seen him and on her initial interview E7 said the CNAs had not seen R3. In a later interview E 7 changed her statement and said that CNA, E8 had delivered R3's tray at 7:30AM, and that R3 was sleeping so she woke him up to eat. On 10/13/04 at 4:15PM, in an interview with E8, it was revealed that E8 had passed a breakfast tray to R3 at around 7:30AM that morning and that R3 was still sleeping in bed. E8 continued that she had collected R3's tray at 8:00AM and he was in his room sitting up in bed; the breakfast tray was on the bedside table and that R3 had eaten all his food. Surveyor noted that the two interviews were conflicting as to the actual time the resident was seen and also the issuance of the breakfast tray. (A)	F9999		