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ALDEN NAPERVILLE REHAB & HCC	**1525 SOUTH OXFORD LANE NAPERVILLE, IL 60565**

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F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS : 300.l1210a) 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. 300.12106) All necessary precautions shall be taken to assure that the resident's environment remains 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. 300.1220b) The DON shall supervise and oversee the nursing services of the facility, including: 300.1220b)2) Overseeing the comprehensive assessment of the rersident's needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential rehabilitation potential, cognitive status, and drug therapy. 300.1220b)3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel representing other services such as nursing, activities, dietary, and such other	F9999		

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modalities as are ordered by the physician shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated be the resident's condition. The plan shall be reviewed at least every three months.
300.3100d)2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device the part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

These REQUIREMENTs are not met as evidenced by the following:

Based on observation, record review and interview the facility failed to supervise a cognitively impaired resident who was identified as a wandering/elopement risk by not:

1. Having a means to continually monitor the front exit door on 9/12/04,12/4/04, and 12/9/04.

2. Implementing care plans for the residents at risk for elopement and not implementing the facility's wanderers(elopement) policy.

These failures resulted in R3 eloping undetected from the facility on 12/4/04 and being found by a passerby on her knees at a strip mall which was down the street from the facility. R3 was sent to the hospital where she was treated for confusion, bruises and a urinary tract infection. R8 eloped from the facility on 12/9/04 and 2/6/05 and was found wandering in the facility parking lot. R7

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eloped from the facility on 9/12/04 and was found at a man's house sitting outside on the lawn, barbecuing and talking.
This was for three residents(R3, R7, R8) out of 7 residents identified by the facility as being at risk for elopement.

The findings include:

1.A review of an admission assessment dated 4/26/04 documents that R3 is 81 years old and was admitted to the facility on 4/16/04. The accumulative diagnosis record dated 4/16/04 documents diagnoses including recent Cerebral Vascular Accident, Frequent Falls, and Vascular Dementia. On 6/23/04 R3 had the additional diagnosis of Dementia with Agitation. A mental status exam dated 4/29/04 documents moderate intellectual impairment. An assessment dated 10/27/04 documents the following: R3 has moderately impaired cognitive skills for daily decision making, has a short term memory problem, and in a test for balance while standing, R3 did not follow directions for the test.
Physician order sheets(POS) dated 12/8/04 through 1/7/05 document may go on therapeutic pass with accompaniment.

A review of nurses notes on 8/17/04 at 6:00am document: resident escorted back inside the building by staff, resident stated she wants to go home. A psychiatric note dated 8/22/04 documents "attempt to leave the building and expressing wishes to go home, may be due to underlying dementia." Nurses notes on 12/4/04 document: 6:00am--sitting in library reading, 7:15 am--in Yorkshire dining room eating breakfast, 9:30am--saw her at medication cart getting her

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F9999	Continued From page 23 meds, 4:00pm--spoke to doctor, states he is aware that resident is returning to the facility. Orders received for Levaquin. An emergency department patient aftercare instruction sheet dated 12/4/04 documents the following regarding R3: Your diagnosis is Dementia, Delirium and you were seen today for your confusion. Urinary Tract Infection/There is an infection in your urine. Bilateral Knee Contusion/Bruises are an injury to a body part caused by a blunt object. An elopement risk care plan dated 8/17/04, 10/27 /04 and 12/06/04 documents the following: has a diagnosis of depression with associated agitation. Noted forgetfulness, confusion and decreased safety awareness. Left facility unattended without purpose, found in general area (near facility) by staff. On 12/06/04 the care plan documents the resident was found in close proximity to facility by a pedestrian, tipped over in her walker and fell down to the ground on her knees. Approaches include the following: discourage her from going out of facility unattended, document occasions when resident leaves facility unattended. A Cognitive Loss/ Dementia care plan dated 4/26/04 through 1/27/ 05 documents resident is unable to make needs known related to severely impaired cognition. E3(Social Service Director) was interviewed on 1/ 18/05 at 12:50pm E3 said R3 went out the front door on 12/4/04 and was found by a passerby on her knees. E3 said R3 missed her home. E3 further said R3 had lived alone prior to coming to the nursing home and she would wander her neighborhood and get lost. E3 indicated R3	F9999		

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would spend her days sitting in the fireside/library room reading. (The library room is located adjacent to the facility's front lobby area.) When asked about R3's safety awareness outside of the facility E3 responded that she does not know if she would stop and look for traffic as there is no traffic in the nursing home to look out for. E3 said R3's judgement is not there and that her friends had handled things for her.

E2(DON) was interviewed on 1/18/05 at 1:00pm. E2 said R3 was not an elopement risk. E2 said if a resident left the facility it would be documented in the nursing notes. R3's nurses notes for 12/4/04 were reviewed with E2. E2 confirmed there was no nursing documentation saying that R3 had left the facility unattended and was found by a passerby.

E4(LPN) was interviewed on 1/18/05 at 1:15pm. E4 worked the 3-11pm shift on 12/4/04. E4 said R3 returned from the hospital on her shift. E4 indicated she was told by the nurses someone came into the facility to tell the nurse someone was down at the corner. E4 said a nurse and a CNA went down to the corner and found R3, who was going home and nobody was going to stop her from going home. E4 did not remember who the nurse and CNA were. E4 said that R3 was not wearing a coat. E4 said R3 would not have had any safety awareness that day because she was diagnosed with a Urinary Tract Infection(UTI). E4 indicated at R3's age a UTI makes you confused. When E4 was asked if she knew how R3 got out of the building she replied there was a new girl at the reception desk and there isn't someone at the nurses station all the time. E4 said a report was filled out and an incident report

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F9999	Continued From page 25 should have been filled out because R3 was confused. E11(Receptionist, Office Manager, Medical Records) was interviewed on 1/18/05 at 12:50pm . E11 said that when R3 lived on the first floor she would try to get out of the facility. E11 said (E12)a week-end receptionist, was working at the reception desk on 12/4/04. E11 told the surveyor E12 told her (E11) she just went to the bathroom and that is when R3 must have gotten out. E12 was interviewed on 1/18/05 at 7:37pm. E12 believes R3 must have left the facility between 11 :00am to 1:00pm. E12 indicated those are the hours when residents eat lunch and she(E12) had to use the washroom and she figured it would be a good time to go. E12 said it was a long time after going to the washroom that a man called and then a lady and her mom who were driving by stopped at the facility to say there was someone down by the grocery store. E12 thought one of the nurses went with the lady in her car to go pick the resident up. E12 said she saw R3 for the first time when she was returned to the facility. E1(Administrator) was interviewed on 1/13/05 at 10:00am. E1 told surveyors incident reports are to be filled out and investigations are done when a resident falls, get slapped, anything out of the ordinary occurs, and if the resident leaves the building. E1 was interviewed on 1/18/05 at 1:45pm regarding R3's leaving the facility on 12/4/04. E1 said R3 was found outside so we brought her back in. E1 did not recall what staff brought R3	F9999		

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back in or at what time it occurred. E1 indicated R3 is allowed out, "they aren't locked in here". E 1 said R3 was found at the grocery store down the street--approximately 200 yards or so. E1 said he believed a staff person saw R3 down there and they came to the facility to let other staff know. E1 indicated there were no records (incident report or investigation) of the incident because it was not an elopement.

E10(CNA) was interviewed on 1/18/05 at 3:10pm E10 worked the day shift on 12/4/04 on the first floor where R3 lived. E10 said somebody called the nursing home to say someone was down at the local grocery store. E10 said "we are busy at that hour." E10 said R3 would talk about wanting to go home. E10 said R3 would walk slowly using a walker.
On 1/18/05 at 3:20pm the surveyor went to the reception desk/ lobby area to obtain photocopies and found no staff was at the reception desk or in the lobby. Four residents were present and selling raffle tickets. At 3:35pm the surveyor again returned to the reception desk/lobby area and no staff person was present.

E13(LPN) was interviewed on 1/19/05 at 2:20am. E13 confirmed she worked the day shift on 12/4/ 04 on the first floor. E13 said R3 was allowed to go outside alone and sit on the front bench. E13 said a passerby came and told them she(R3) was at the grocery store. E13 said that R3 was diagnosed with a UTI on that day. E13 said she last saw R3 when she received her 9:00am medications. E13 does not remember R3 going to the hospital and believes it must have occurred on the 3-11 shift. E13 said after R3 returned to the nursing home and was on the Pathways unit(

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F9999	Continued From page 27 secured unit) the administrator told R3 if she needs to go shopping she must tell someone at the facility. E13 said a nurses note was written on 12/4/04 about R3 being gone from the facility and an incident report was filled out. E13 was not aware R3 was an elopement risk. Z1(Physician) was interviewed on 1/19/05 at 11:50am. Z1 said R3 wanted to go home but R3 is not aware of where she is(nursing home) or why they are there. Z1 said when you ask residents were home is that it might be at 75th street and they would go by streetcar which no longer exists . Z1 said that R3 got out of the facility once before and that she is an elopement risk. Z1 said R3 appears intact but when you get into her thoughts there is nothing there and there is no safety awareness. Z1 said R3 does have a Vascular Dementia and she definitely is Agitated--if she wants to go home she wants to go home. R3 was observed laying in her bed and was interviewed on 1/20/05 at 9:30am. R3 remembered the day when she fell in the snow. R3 said she was going home but that her knees gave way. R3 gave the surveyor a street address in the suburb of Winfield and said her home was by the railroad tracks. R3 did not know if her home was still there. R3 did not remember going to the hospital on that day. A review of the facility's Wanderers(Elopement) policy documents the following...the charge nurse will obtain an order for the use of an identification band for the purpose of denoting potential for wandering. E2 was interviewed on 1/20/05 at 10:25am. E2 said that nobody in the facility wears identification bracelets and R3 did not have	F9999		

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F9999	Continued From page 28 physician orders for one. A review of the local weather history for 12/4/04 reveals the temperatures ranged from 37 degrees Farenheit at 9:53am to 39 degrees Farenheit at 3:53pm. The mileage by car measured the distance from the nursing home parking lot to the grocery store at 3 tenths of one mile. 2. A review of the facility's admission-discharge form documents that R8 is a 67 year old who was admitted to the facility on 5/15/03. A review of POS dated 12/8/04-1/7/05 document orders, initiated on 1/12/04, of therapeutic pass with medications in instructions with accompaniment as necessary. There are no orders to allow the resident to go out of the facility unaccompanied. Assessments dated 5/25/2004 and 11/23/04 document the following regarding R8: has short-term and long-term memory problems, moderately impaired cognitive skills for daily decision making, and exhibited wandering(moved with no rational purpose, seemingly oblivious to needs or safety) in the last 7 days. A mood state resident assessment protocol(RAP) dated 5/25/04 documents the following: Diagnosis of Anoxic Encephalopathy and Dementia, restlessness, many attempts to leave facility unattended. A cognitive loss/dementia rap dated 5/25/04 documents R8 is unable to make needs known related to severely impaired cognition. An elopement risk care plan dated 12/9/04 documents R8 self-propels his wheelchair throughout the facility. Often needs redirection due to movement without purpose or directions.	F9999		

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A nurses note dated 12/10/04 11:00am documents the following: Both the doctors office and son were given information regarding R8's wandering into parking lot yesterday. There were no nursing notes in R8's record for 12/9/04. This was confirmed with E2 and E3 on 2/3/05 at 11:50 am.

E2 and E3 were interviewed on 2/3/05 at 11:50 am. E2 was questioned regarding any documentation regarding the nurses note of 12/10/04. E2 said the 12/10/04 note was written because R8 had wandered into the parking lot on 12/9/04 and because of this an elopement care plan was developed. E3 was asked about the " many attempts to leave the building" documented on the mood rap of 5/2004. E3 confirmed there was no care plan specific to elopement in place prior to 12/9/04. E3 did recall an incident where R8 did go out the front door and fell on the curb. E3 could not recall the exact date of that occurrence.

Z5(Family) was interviewed on 2/8/05 at 11:00am . Z5 said he was at the nursing home on Sunday 2/6/05--just prior to the Super Bowl Game to visit R8. Z5 said when it was time to leave he left R8 by the double doors nearest to the first floor nursing station. Z5 said he told R8 to stay there. When Z5 got into his car which was parked in the front parking lot, he saw R8 in his wheelchair out on the sidewalk saying he wants to go home. Z5 said he took R8 back into the nursing home. Z5 said the staff at the front desk told him she had just put her head down. Z5 said "my dad does not move that fast in his wheelchair."

3. A review of the facility's admission-discharge

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F9999	Continued From page 30 form documents that R7 is a 54 year old who was admitted to the facility on 4/18/03. A review of POS dated 12/8/04-1/7/05 document orders, initiated on 4/18/03 for therapeutic pass with medications in instructions with accompaniment as need. There are no orders to allow the resident out of the facility unaccompanied. An accumulative diagnosis record dated 4/18/03 documents the following diagnoses: Cerebral Vascular Accident with Right Hemi Expressive Aphasia, Alcohol Abuse and Depression Assessments dated 5/3/04 and 8/2/04 document the following regarding R7: has short-term and long-term memory problems, moderately impaired cognitive skills for daily decision making and is sometimes understood when trying to make self understood, A cognitive loss/ dementia Rap dated 5/3/04 documents R7 is dependant on staff to monitor for and anticipate needs. A fall care plan dated 5/3/04 through 2/1/05 documents R7 is at high risk for falls. A vision care plan dated 5/3/04 documents R7 has no peripheral vision. A mood state/behavior/ elopement precautions care plan dated 9/16/04 through 5/1/05 documents R7's sister has requested resident must be accompanied by family, friends to leave the facility. An activities of daily living care plan dated 2/1/05 documents is monitored closely due to high risk for leaving facility. Nurses notes dated 9/12/04 document the following: 5:00pm--reported by CNA that this resident (R7) was ambulating with fast steady gait to 2 blocks away from the facility and disappeared. 5:30pm--CNA drove car to look for resident of her	F9999		

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whereabouts.
6:55pm--Another staff brought this resident back to the facility after searching for the resident. Resident was found in a man's house, sitting outside the lawn, barbecuing and talking.

A social service note dated 9/13/04 documents the following: Is alert but forgetful. Facility is concerned about overall safety issues. Spoke to resident 1:1 about issues and facility concerns. Exhibits limited understanding. Has been redirected back into facility 3 times since recent conversation.

E3 was interviewed on 2/3/05 at 11:40am. E3 said at first R7 liked to walk around outside of the building and then she was allowed to walk in the parking lot and then was allowed to go to the local grocery store. E3 said on 9/12/04 an aide had gone out for dinner and saw R7 was going North. E3 explained the local grocery store was South and R7 was not allowed to go North. E3 said the staff saw her turn West on one of the streets which is a residential area. E3 said that when other staff who were looking for R7 talked to the neighbors, the neighbors were aware of her because she would go down that way and visit. E3 said that R7's judgement is definitely impaired because of a history of drug and alcohol use.

Z2(Family) was interviewed on 2/7/05 at 11:00am . Z2 said the nursing home let her(R7) run all over the neighborhood since she was admitted. Z2 said she was told by the facility they don't believe in restraining residents. Z2 said she would visit R7 approximately every 2 months. Z2 said the people down at the local grocery store

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(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
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would tell her they had all kinds of people in the store who came from the nursing home and that these people would be falling off the curb. Z2 said she talked to the hair dresser at the beauty shop adjacent to the local grocery store when she came to visit and found her sister's hair had been cut. Z2 said that Z4(Hair Dresser) told her that Z3(Male friend who lives near nursing home) brought R7 into have her hair cut to make her feel better. Z2 said Z4 told her R7 had been found at Z3's home when they were having a barbecue. Z2 added R7 is very attractive and she could be take advantage of sexually--she has been in some very bad relationships.

Z6(Physician) was interviewed on 2/8/05 at 11:10 am. Z6 said she(Z7) is not safe. Z6 said staff at the nursing home told her they were unaware R7 had been going outside of their area. Z6 said she had seen R7 smoking and that she was okay to go outside with friends. Z6 said that R7 looks normal but that you cannot count on her cognition --she cannot read or write, she cannot communicate properly. Z6 added "I don't know how much R7 comprehends, she is well dressed, takes care of herself well, is very friendly and lonely. R7 would not have the awareness to know if she were in trouble--I (Z6) would be very worried about her.