STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145696	A. BUILDING _____ B. WING _____	C 03/30/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON PLAZA NSG & REHAB CTR	**9777 GREENWOOD NILES, IL 60714**

(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 Licensure 300.1210a) 300.1210b)4) 300.1210b)6) 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 shall be provided 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. These regulations are not met, as evidenced by the following: Based on interviews and record reviews, the facility failed to:	F9999		

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F9999	Continued From page 6 1. Properly supervise one resident (R3) with a known history of wandering, poor safety judgement and falls; 2. Activate an alarm for a stairwell located at the end of the north hallway. Facility staff were unaware that R3 had gained access to the stairwell, resulting in R3 falling down stairs and sustaining skin tears to R3's left leg. Findings include: 1. R3 is a 71 year old with diagnoses including Dementia with Psychosis, Arthritis, Degenerative Joint Disease, History of Coronary Artery Disease and Hypertension. Physician's Orders (2 /2005) note the following medications: Atenolol, Lodine and Exelon, Seroquel and Depakote. R3's assessment dated 12/01/2004 and 03/01/ 2005 was reviewed. R3's score for Cognitive Skills for Daily Decision-Making was a "2"... modified independence. R3 was scored as "1/0" under Behavioral Symptoms for wandering (moved with no rational purpose, seemingly oblivious to needs or safety)...behavior of this type occurred 1 to 3 days in last 7 days/behavior not present OR was easily altered. Under the category Modes of Locomotion the following were listed: wheeled self, other person wheeled and wheelchair primary mode of locomotion. Under the category Accidents, it was documented that R 3 had fell in past 30 days and fell in past 31-180 days. Under the category Devices and Restraints it was documented that chair prevents rising (12/ 01/2004 only).	F9999		

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F9999	Continued From page 7 R3's care plan (12/06/2005, 03/01/2005 and 03/07/2005) documents the following: identified as a wanderer, wanders near exits; need to monitor behavior manifested by wandering and identified wanderer related to dementia. The following approaches were listed: close supervision, 1:1 visits. R3's Physical Restraint Assessment (09/02/2004) documents that R3 has poor body control, unsteady balance, slides down in chair, will get up without assist, decreased safety awareness, decreased balance. Review of Physician's Orders (02/2005) documents the following order: soft waist belt while up in wheelchair due to poor standing balance, history of falls, decreasing safety awareness, due to diagnosis of dementia with psychosis. Review of R3's Nurse's Notes (02/05/2005) documents the following: "fall; at 100 PM, resident calling "Help! Help!"... RN went to north stairwell, observed resident inside wheelchair, upside down, attached to wheelchair with safety belt, left ankle caught in between stair rails. Skin tears left lower leg." R3 was observed on 3/24/2005 sitting in a wheelchair in the 2nd Floor Dining Room. A soft restraint was noted around the resident's waist. R 3 was awake, alert and confused. 2. E12 (Registered Nurse) stated during interview that she found R3 after lunch between 12:30 PM and 1:00 PM. E12 stated that she	F9999		

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F9999	Continued From page 8	F9999		

heard a noise and started checking residents' rooms. She then heard an"echo sound" and went to the 2 North Stairwell and found R3 halfway down the second set of stairs in the stairwell, hanging upside down in the wheelchair ...tied with soft waist belt and left leg was stuck between the hand rails. E12 stated that she did not recall whether or not the stairwell alarm was on, however, she stated that she did not recall hearing the alarm.

3. E10 (Licensed Practical Nurse) stated during interview, that E12 found R3. E10 informed the surveyor that when she first observed R3 after the incident of 02/05/2005, R3 was in the wheelchair, upside down, still with lap belt on and left leg wedged in between handrail. E10 also stated that R3 usually wanders around the unit, though not down the North Hallway. E10 further stated that she had encouraged staff (CNAs) to watch/observe/supervise R3 and that she felt that R3 was in need of 1:1 supervision.

4. E4 (Registered Nurse) stated during interview that R3 has a history of wandering and that the alarms to stairwell doors are not generally activated unless a wandering resident has tendencies to wander to stairwells.

5. E6 (Certified Nursing Assistant) stated during interview that he did not know if the stairwell alarms were activated at the time of the incident and was unsure if the alarms were to be on at all times. E6 also stated that R3 was sitting half way up the the stairwell immediately in front of the 1st Floor North Stairwell door.

6. E7 (Certified Nursing Assistant) stated during

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F9999	Continued From page 9 interview that R3, a known wanderer, was half way up the set of stairs immediately in front of the 1st Floor North Stairwell door, still in wheelchair with lap belt on. E7 further stated that at the time of the incident, the alarm to the North Stairwell was not activated. 7. E8 (Licensed Practical Nurse) stated during interview that she knew that R3 would have a tendency to wander due to R3's diagnosis of Dementia and required additional supervision. She also stated that the alarm to the 2nd Floor North Stairwell was not activated at the time of the incident. 8. The facility's incident report for this incident was reviewed and documents: RN heard resident calling for help by north stairwell. Observed resident fell on the stairs, still in her wheelchair with safety belt on. No loss of consciousness, range-of-motion to right lower extremities are within normal limits; complaining of pain on her left lower leg. Small abrasion on left lower leg noted. 911 called. Attending physician and family notified.	F9999		