STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145939	A. BUILDING _____ B. WING _____	C 08/23/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT TERRACE	**7750 SOUTH SHORE DRIVE CHICAGO, IL 60649**

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F 492	Continued From page 8 -Nurses Notes dated 07-31-05 at 9:30 PM stated, " Resident returned to the facility ambulatory, alert to name accompanied by the local police." The Nurses notes and Incident Report dated 07-31-05 at 8:00 AM confirmed R4 was missing from the building on 07-30-05 until the next night. Review of the facility elopement policy and procedures dated 07-2002 stated," Within 24 hours of elopement, whether or not the resident had been located and returned to safety, the Illinois Department of Public Health (IDPH) shall be notified of the incident. This report shall include: - The name of the resident - The time the resident was found missing. - The time the resident was returned to the facility. - The extent of any injuries or illness with the resident. E2 (Director of Nurses), on 08-17-05 at 11:49 AM on the fourth floor conference stated,"I did not investigation the incident of R4 leaving on 07-30-05 the building and not found until the next night. I did not notified DPH." Surveyor asked E at 3:00 PM, did she do investigation on the elopement of R and fax incident to DPH. E stated," No, I did not investigated the incident nor fax it to DPH.	F 492		
F9999	FINAL OBSERVATIONS STATE VIOLATIONS ASSOCIATED WITH THIS	F9999		

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F9999	Continued From page 9 SURVEY: 300.610 a) 300.1210 a) 300.1210 b)6) 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 there under. 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. 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. 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	F9999		

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F9999	Continued From page 10 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 record reviews and interviews, the facility failed to adequately supervise one resident (R4) to prevent him from leaving the building. R4 left the facility on 07-30-05 undetected by staff. R4 was assessed and identified by the facility as being high risk for elopement and he has dementia with organic brain syndrome (OBS). This situation put R4 at immediate risk for harm. R4 left out the facility one night (07-30-05) and was not found until the next night (07-31-05 at 9:30 PM). R4 was found over 20 miles away from the facility and returned back to the facility by the local police. Finding Include: Review of the facility's Elopement Risk Policy and Procedure dated July, 2000 states: * Resident who are at risk shall be provided at least one of the following : * An electronic wander safety device or other personal safety device that will notify the facility when the resident has left the building without supervision.	F9999		

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F9999	Continued From page 11 * Staff supervision, either by visual contact or by video camera of the facility exits. * The critical importance of responding to and investigation the cause of an alarm sound. * Notify physician of residents' confused and/or agitated state and residents' increased risk for elopement. * Monitor one on one by staff until behavior subsides. * During one on one monitoring log should be documented in every 15 minutes. The closed clinical record review stated that R4 is a 68 years old male with diagnoses Dementia, Organic Brain Syndrome, Glaucoma and Hyperglycemia. The documented Elopement Risk Assessment Tool, dated 06-21-05, reveals that Resident is confused to time, place and has physical ability to leave the facility. The Care Plan dated 07-20-05 identifies that the resident attempted to elope and is confused. R4's nurses' notes reviewed states the following: - Nurses notes dated 07-20-05 states, "Confused and Mental status change. Attempted to elope." - Nurses notes dated 07-31-05 at 8:00AM stated, "Resident was called for breakfast with no response. Room check. Resident not in room. Roommate (R5) stated, "resident did not sleep in his bed last night." Resident was paged (times two). Rooms checked unable to locate." -Nurses notes dated 07-31-05 at 9:30PM - Resident returned to the facility ambulatory, alert to name accompanied by the local police. The Nurses notes and Incident Report dated 07-31-05 at 8:00AM confirmed R4 was missing from the building on 07-30-05 until the next night.	F9999		

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F9999	Continued From page 12 Review of the residents' assessment, Section B4: Cognitive Skills For Daily Decision-Making states the following; -06-27-05 - Score 2, Moderately Impaired - decision poor; cues / supervision required. During the interview with E2, (Director of Nurses) on 08-18-05 at 10:15AM in the conference room, stated, "I had a resident (R4) leave the building on 07-30-05. I don't know how long R4 was missing. I was notified on 07-31-05 at 8:00AM that R4 was missing. The staff did not realize R4 was missing until next day. He was found on the north side, lying on grass by local police. He went to a North Side Housing Project. The resident should not have been able to leave the facility because the door exit alarm should have sounded." In an interview with E3, (Certified Nurse Aide - CNA) on 08-17-05 at 12:20PM, per telephone, E3 stated, "I was the only CNA on the floor. I work the 3 PM - 11 PM shift. It was on 07-30-05, I was passing out linen on the floor, when I saw him (R 4) sitting in the hall. I asked if he want anything off of the linen cart. I did my rounds. I saw R4 between 5:30PM - 6:00PM during dinner. He had dinner in the first floor dining room. That was the last time, I saw R4. From 7:00PM to 11:00 PM, I was finishing putting residents into bed. At 11:00PM, I did round and was done. I did not see R4 in the room. I thought he was in the building. I did not search for him. The exit door alarm should have sounded. I did not hear the exit door alarm go off." In an interview with E6, (CNA) on 08-17-05	F9999		

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F9999	Continued From page 13 at 12:30PM per telephone, E6 stated "When I got to work that morning R4 was not in the room. I start work at 7:00AM. When I was making rounds R4 was not in the room, his bed had not been slept in. I look in all the rooms. I ask R6 (roommate of R4) where is R4. R6 stated, "He had not seen him since supper time the day before, (Saturday 07-30-05). I started to look for him and I told the nurse." E7, (CNA) was interviewed on 08-17-05 at 1:00 AM on 1st floor and stated, "A resident (R4) was assumed to be out with the family. He was assumed out on a pass. We found out he was not out on pass with family." R5 was interviewed on 08-17-05 at 1:15PM in the room stated, "He (R4) just left! He just left! It was late at night. He did not sleep in his bed that night. I just told you he did not sleep in bed that night." Surveyor asked R6 " Did staff come in to check on them? " , and R6 stated, "No, I did not see anyone that night. I seen someone the next day (07-31-05) when they ask me about him. I told them R4 did not sleep in his bed. The door alarm sounded. I heard it! I told you! I heard the door sound off." In an interview with E8, (CNA) on 08-17-05 at 1:30PM per telephone E8 stated, " He (R4) was missing when I go to work. It was on the weekend (07-30-05 and 07-31-05). R4 was missing from the building." E13, (Nurse) was interviewed on 08-17-05 at 8:00PM per telephone and stated, "I start duty at 7:00AM. I did my report and started hall rounds". E13 told surveyor she did not see R4 during her	F9999		

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F9999	Continued From page 14	F9999		

morning rounds. R4 usually ambulates in the building. "I call him on the intercom". R4 did not come up to the floor. I went down to the kitchen and kitchen workers did not see R4 on the lower level. We look around the building. He was not in the building. This was approximately 8:00AM. I ask R5 where was his roommate. He stated, "R 4 did not sleep in the bed. R4 usually ate in the basement dining, but we were concern about his changes in mental status. So, R4 eats his meals on the floor."

Z1 (Family Member), on 08-17-05 at 5:30PM stated, "The staff call me on the July 30, 05 at 9:30AM. The staff told me R4 was missing. She ask if we had him at home. We said No. She call back within 10 minutes and reported R4 was missing. We search the building R4 was not there. They call the police and made a report. We stay at the facility until 10:00PM. He was found on 07-31-05 approximately 20 miles from the facility. He was found lying on the grass. They said he was observed at dinner on 07-30-05 at 5:00PM. That was the last time the staff saw him. He was monitor after that time. R4 is very confused and has mental changes. He also has Alzheimer in the fourth stage. "

In an interview with E12 (Director Social Service), on 08-18-05 at 10:30AM stated, "R4 tried to get out the facility in July 2005. The staff saw him and brought him back. The staff was aware R4 wanders and is at high risk for elopement. R4 became more confused in June, 05. The staff is supposed to monitor him. He was not allowed in the lobby, because we had concerns about his mental status changes."

(A)