STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145689	A. BUILDING _____ B. WING _____	C 08/31/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE AT ELK GROVE VILLAGE	**1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 324	Continued From page 9 determine staff ability to distinguish between residents and visitors to be conducted weekly x 4 weeks. Results to QAA.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological 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. Restorative measures shall include at a minimum the following procedures: b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 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. Based on record review and interview, the facility failed to adequately supervise and properly	F9999		

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F9999	Continued From page 10	F9999		

intervene for one resident R3 to prevent her from leaving the building. R3, who was a new admit (7/26/06), left the facility on 7/28/06 at approximately 3:15 AM at night. Staff did not prevent R3 from leaving because staff believed that R3 was a visitor and allowed her to leave out the front door.

Findings include:

Record review showed that R3, a 71 year old female was admitted to the facility from the hospital on 7/26/06 with multiple diagnoses that include Diabetes Type II, GI Bleed, Mass Transverse Colon, Hx of Breast Ca, S/P Bilateral Mastectomies, Hx of Lung Ca and Right Lobectomy. R3 was also on multiple medications that included Zoloft (Anti-depressant).

Review of the nurses notes dated 7/27/06 showed that R3 was seen by the physician and ordered to discontinue Zoloft and change to Lexapro 10 mg. It was also noted that E5 (Clinical Psychologist) was on consult Re: Anxiety and left message.

Review of E5's Diagnostic Interview Examination dated 7/28/06, showed as follows: "Most Recent Hospitalization: 7/15/06 GI Bleed, S/P Left Hemicolectomy for Tubulovillous Adenomas. History: Admitted 7/26/06 to subacute rehab with Dx (Diagnoses) above plus IDDM (Insulin Dependent Diabetes Mellitus), Depression, Low K (Potassium), HTN (Hypertension), and Anemia." Also noted Lexapro as one of the current routine orders. Diagnostic Impression as follows: Delirium, onset post surgical, Pre-existing Dementia process, etiology not worked up and Major Depression, Single

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F9999	Continued From page 11 Episode, Moderate Severity, onset 6-9 months. Significantly impaired safety awareness/judgement, reasoning, short term recall, word finding, attention and concentration were noted. Review of the facility Incident Report dated 7/28/06, prepared by E3 (Nurse-Night Supervisor), showed that "Resident (R3) could not be located at approximately this time (4:00 AM). Code Green (For Missing Resident) was called and facility search conducted. Supervisor on Call (E3) notified, Administrator (E1), Daughter (Z6) and MD (Z1) notified. Z8 police notified and found resident (R3) minutes later. No injury noted." Review of E1's Investigation Report dated 7/28/06 showed that at approximately 3:15 AM on 7/28/06 the main front entrance door alarm sounded and was immediately responded to by three CNA's (E7, E8, E10). E7 (CNA-Certified Nursing Assistant) confronted a female (who later was determined to be the patient) who indicated she was using the visitor rest room and was now leaving the facility after visiting a friend. The female visitor who had the rest room key in her hand returned it to the wall hook. The patient was alert and oriented. It was not determined that the resident was missing until after the staff nurse notified the supervisor at 4:00 AM. The police located the resident outside a nearby retail pharmacy at approximately 5:00 AM and returned the patient back to the facility after she refused to go to the hospital for examination. Interview with E3 on 8/29/06 at 9:00 AM, facility conference room, revealed that two local police officers brought the resident (R3) back to the facility at approximately 5:45 AM.	F9999		

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F9999	Continued From page 12 Review of the Admission MDS (Minimum Data Set) dated 8/7/06, which was ten days after the incident, showed that under Section B, Cognitive Skills for Daily Decision Making, Score 1. Modified Independence-some difficulty in new situations only. R3 was only in the facility for two days and needs supervision. Under Section G, Walk in Room, Walk in Corridor, Locomotion On and Off Unit, are all Scored 2/2, which indicates that R3 needs Limited Assistance/One Person Physical Assist. During the incident, the police report noted that while R3 was walking, R3 fell and was unable to get up. Interview with E7(CNA) on 8/29/06 at 10:00 AM, via telephone, revealed at approximately 3:15 AM, E7 heard the main entrance door alarm go off. E7 went up to the door and saw a woman standing by the key pad, trying to enter the code to get the alarm off. She had the women's bathroom key in her hands. E7 asked her: "Are you trying to get out ?" The woman said "Yeah." E7 told her that she cannot go out with the key. The woman turned around and returned the key to the wall hook. The woman then turned around and walked out the door. E7 disalarmed the door for around two minutes. E7 told surveyor that she thought that the woman was a visitor. Surveyor asked E7: "Why didn't you ask questions just to confirm that she was a visitor and did you even wonder who the woman is leaving at such odd hour?" E7 told surveyor that the woman was fully dressed with a purse on her shoulder, and did not think that she was a resident at all. She was also familiar with the key to the women's washroom. E7 further stated that some of the visitors know the code to turn off the alarm if they want to go home during the night. There are visitors who go	F9999		

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F9999	Continued From page 13 home late depending upon the condition of the resident who they are visiting. When this incident happened, E7 was assigned in Station C, 11-7 shift, where R3 resides in Room 301-B. E7 told surveyor that she did not know the resident (R3) and was not assigned to R3 that night. E7 has been with the facility as a CNA since 10/1/05. Interview with E8(CNA) on 8/29/06 at 10:10 AM, via telephone, revealed she was working in Station A when she heard the alarm. E8 and E10(CNA) went to the front door. E7 was already there. E8 stated that the resident opened the door on her own and the alarm went off. She was dressed in regular street clothes. All E8 saw was the resident's back. She had the women's bathroom key in her hands, that is why we also thought that she was a visitor. Surveyor asked E8: "Why didn't you ask her questions just to check if she was really a visitor?" E8 responded: "No because she was already half the door and we think that the other CNA(E7) already took care of it." E8 further stated that when the supervisor(E3) called "Code Green," they responded and figured out that the woman in the front door earlier might be the missing resident. When surveyor asked E8 if visiting hours are being followed, 10:00 AM-8:00 PM, E8 responded that the facility is not enforcing the visiting hours. Interview with E4(Nurse) on 8/29/06 at 9:40 AM, via telephone, revealed E4 saw R3 sleeping at around 1:00 AM that night. At approximately 3:45 AM, E4 went to R3's room and did not see her. E4 told the other nurse(E5) and the CNA's that R3 was not in her room. Staff checked the other resident rooms, washrooms, parking lot and area around the building and did not find her(R3). E4	F9999		

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F9999	Continued From page 14	F9999		

reported it to the supervisor who called "Code Green." When surveyor asked E4 about the visiting hours, E4 stated that it was not really followed. There are some visitors who stay late and go home late.

Interview with E5(Nurse) on 8/28/06 at 4:00 PM, via telephone, revealed that she was working in Station C that night but was not assigned to the resident(R3). When "Code Green" was called, E5 went to her car and drove around the area, but was unable to locate the resident. The police located R3 within 30-45 minutes by a retail pharmacy in Plum Grove Road, within the same block as the facility is located. The CNA who was assigned to R3 that night is no longer working in the facility.

Interview with Z2(R3's Daughter) on 8/28/06 at 3:40 PM, via telephone, revealed that it was noticed that R3 was beginning to have dementia for the last six months. R3 experiences difficulty expressing herself. R3 cannot put a clear sentence together and asks the same questions. My sister(Z6) was notified by the facility and went there that morning when the incident happened.

Interview with Z3(Police Officer) on 8/29/06 at 9:18 PM, via telephone, revealed that R3 was located by a jogger who flagged down Z3 as Z3 was driving in the area. R3 was found behind the Z7 building in the southwest corner of Nerge and Plum Grove Road, in a grassy area. The place is south of Nerge Road. From the front door of the facility it is about 200 yards. R3 was standing when Z3 saw her. The jogger found R3 lying on the ground and the jogger helped R3 get up. R3 refused to be taken to the hospital. R3 kept on saying that she wants to visit her brother. Z3

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F9999	Continued From page 15 confirmed that Nerge and Plum Grove Roads are both busy streets. Interview with Z4(Police Officer) on 8/29/06 at 10:05 PM, via telephone, revealed that Z3 was already with R3 when he arrived. Z4 further stated that R3 was found around their (Z3, Z4) closing time, so 5:30-5:45 AM sounds right. The location where R3 was found is south of Nerge Road. Surveyor told Z4 that if R3 was found in that location, R3 then crossed Nerge Road. Z4 responded: "Yes she did." The facility is north of Nerge which is a busy street. Review of the Police Report #06.11981 showed that it was later discovered by the facility that the subject was R3. Upon checking the area the staff found a bag containing R3's personal belongings under the desk at the front entrance. While searching the area of Plum Grove and Nerge, E3 and E4 were flagged down by a citizen. This citizen advised the police officers that he found an elderly female subject near a tree in the area of Nerge and Plum Grove. The citizen was able to direct them to the area where the officers located R3. R3 stated that she was attempting to walk to a relative's house when she (R3) fell and was unable to get up. R3 was transported back to the facility by the police officers. (A)	F9999		