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	145549	A. BUILDING ______ B. WING ______	C 03/07/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN NURSING HOME	**11401 SOUTH OAKLEY AVENUE** **CHICAGO, IL 60643**

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F 324	Continued From page 6 assisted by staff to secure the front lobby and door. 6. Current practice reviewed and updated on 2/19 that at 8:30pm, the front lobby is locked and door to front lobby is alarmed to prevent anyone from exiting the building unnoticed. 7. On 2/20, Elopement ID bracelets were placed on all residents at risk for elopement. 8. Inservices were provided to ancillary staff and all receptionists, as well as nursing staff and department heads, and was completed 2/20. 9. A plate was placed over the 2nd floor elevator button on 2/20 to prevent access by residents; a peg is used to operate the elevator button currently. 10. Quality Assurance staff discuss all behavior and incident issues upon occurrence and in the 24 hour daily meeting. This was in place on 2/20 and is ongoing; the Administrator and the Director of Nursing will continue to review on an ongoing basis for the need for improvement. Although the Immediate Jeopardy was removed on 2/20/06, the facility remains out of compliance at a severity level 2 to allow for implementation of all of the above responses.	F 324		
F9999	FINAL OBSERVATIONS 300.1210 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	F9999		

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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:
300.1210 a)5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.
300.1210b)3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
300.1210 b)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 interviews, the facility failed to adequately supervise 1 resident (R2) who had been diagnosed with Alzheimer's disease and who was identified as being at high risk for elopement, and failed to adequately monitor the front door on 2/19/06, in order to prevent R2 from leaving the building.

Findings Include:

During interview with E1 on 2/28, E1 stated that R2 had only recently been admitted to the facility,

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F9999	Continued From page 8 and was considered an elopement risk because of an incident on 2/11, when he became agitated after being told he couldn't leave. At that time, R2 's picture was placed at the front desk, so that the receptionist could identify R2 should he attempt to leave through the lobby. E1 stated that all the alarm doors were checked and found to be working. E1 stated that a CNA (E4) saw R2 on the elevator, but couldn't stop the door from closing. R2's CNA (E3) went down to the front lobby, and looked on the 1st floor and outside, but did not see R2. E1 stated that a thorough room to room search was done on all floors, as well as a search of the grounds and a search of the local area by car was done, without success. Police and local media stations were notified, and the facility staff continued to search, widening their search area to include the area where R2 used to live. E1 stated that there was a receptionist on duty on 2/19, but that she did not see R2 leave through the front door. E1 stated that they believe that R2 was able to leave through the front door undetected because it was a very busy day at the facility, with lots of visitors coming and going. E1 stated that 2 residents were having birthday parties that day, as well as an educational program that was taking place, so there were many visitors entering and leaving. E1 stated that staff continued to search for R2, and he was located in his old neighborhood (approximately 12 miles away from the facility) the next day, by Z2 (Management Consultant), and was returned to the facility. E1 stated that Z2 observed R2 walking down the street and called to him, and R2 came over to Z2's car and got in. According to E1, R2 had fallen, and sustained multiple abrasions; he was examined by Z3 (physician for R2) and x-rays were taken, which	F9999		

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were negative for fracture.

Review of R2's medical record reflects that R2 is 75 years old, and has Alzheimer's Dementia, impaired vision and impaired cognition. R2's care plan entry of 2/11 reflects that R2 previously attempted to elope on 2/11, and also has difficulty gathering and expressing his thoughts. R2's care plan entry of 2/13 also identifies that R 2 is at risk for falls. R2's care plan also reflects that R2 is alert and oriented with episodes of confusion that requires constant redirection. Review of R2's nursing notes dated 2/11 at 3:30 pm reads as follows: "Res noted attempting to elope, approached calmly by staff. Res noted swinging on staff with hanger and shoe grip holder, contained by staff and redirected...". At that point, nursing notes reflect that R2's physician, Z3, was contacted, and that new orders for medication and a psychiatric evaluation were received.

Review of R2's MDS (Minimum Data Set) of 2/6/06 reflects that R2 is scored a "2" for cognition, indicating that R2 is moderately impaired for daily decision-making. This MDS also reflects that R2 has a memory problem, impaired vision and the behavior of wandering.

During telephone interview with E3 on 2/28, E3 stated that he was R2's CNA on 2/19, and that he was told by E4 that she had just seen R2 on the elevator. E3 stated that he had seen R2 in the dining room a short while before, and saw him in the hallway talking to someone about 10 to 15 minutes prior to him being seen on the elevator. E3 stated that R2 was wearing his coat and hat in the facility, but that he had done this before.

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When E4 told him about seeing R2 on the elevator, he took the next elevator down, and went to ask the receptionist if she had seen R2 leave. According to E3, the receptionist told him that some family members had left, but that she hadn't seen R2. E3 stated that he went outside and checked around the building, but did not see him, and then he came back into the building, and checked for him on the 1st floor and in the basement, but could not find him. He stated that he alerted staff on each floor that R2 could not be found, and then he continued to search, going out in his truck and driving through the local neighborhood and in an adjacent suburb, without success. E3 stated that he had, on other occasions, seen R2 walking with his hat and coat on, approaching the elevator, but he could be redirected back to his room.

During interview with E7 (Data Entry/Reception) on 2/28, E7 stated that she was covering for the full-time receptionist on 2/19, and she stated that the front door alarm is turned off at 8:00am. E7 stated that part of her duties as receptionist are to have visitors sign in and out and monitoring of the front door. E7 stated that there are 2 main doors in the front lobby, and then across the lobby, there is an inner door which enters into the first floor nursing unit. For someone to enter through this door to the nursing units, they must be buzzed in, but anyone can exit through that door into the lobby without any alarm or being buzzed out; this door is not alarmed. E7 states that R2's picture was posted at the reception area due to the possibility of elopement, and that she had never seen R2 except for his picture. E7 stated that 2/19 was an extremely busy day at the facility, because 2 residents were having

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F9999	Continued From page 11 birthday parties that day, and they had many elderly visitors coming and going. The first notice she had that anyone was missing was when E3 came to the lobby to ask if she had seen R2, but she hadn't. E7 also stated that because of the parties taking place, a family member had been holding open the door leading into the nursing unit, while other family members carried in chairs and food, which isn't usually done. During interview with E6 (LPN) on 3/1, E6 stated that she was functioning in the role of nursing supervisor on 2/19, and spent a good deal of time at the reception area. She also stated that she covers the receptionist when the receptionist goes on break. E6 stated that she also observed visitors holding the inner door open, allowing other family members to carry items in for the birthday party. E6 stated that when she is at her usual desk in the reception area, she does not have a good view of people coming and going, because the desk she uses is set back from the front reception area. E6 stated that with all the traffic coming and going, it would have been difficult to identify R2 as a resident, because when he was dressed, he looked like any other elderly visitor that was coming in and leaving that day. Review of R2's nursing notes reflect that R2 was re-admitted to the facility on 2/20, and his admission nursing assessment done at 2:38pm reflects that R2 sustained multiple lacerations and bumps. R2's incident report dated 2/20 stated that R2 reported falling while he was out of the building, and reflects that R2 sustained multiple abrasions and bumps. Nursing notes reflect that R2 was examined by Z3 (physician for	F9999		

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R2), with multiple x-rays ordered, which were all negative for fracture. First aid was administered to the abrasions. Medical record review reflects no other treatment was necessary.

During telephone interview with Z3 on 3/2, Z3 stated that he examined R2 on 2/20, upon his return to the facility, and that R2 told him that he had fallen, but because of his Dementia, could not provide specific details of how he fell. Z3 stated that R2 sustained a skin tear, as well as multiple abrasions and contusions, and that only cleansing and bandaging of the wounds was required. Multiple x-rays were done, and were all negative for fracture. Z3 stated that R2's injuries were consistent with a fall.

Section 300.7020 Assessment and Care Planning
a) Resident assessments, in addition to requirements in other applicable State and federal regulations, shall include a standardized, functional, and objective evaluation of the resident's abilities, strengths, interests, and preferences. The assessment shall be completed within 14 days after admission.
1) Assessments shall include at least a behavioral and a functional assessment, as well as direct observations of the resident. The facility shall attempt to interview the resident, the resident's family, the resident's representative, and recent and current direct care givers. This attempt shall be documented.
2) Assessments shall include at least the following:

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F9999	Continued From page 13 A) daily routine; B) dining, mealtime approaches, and non-mealtime nutrition and hydration needs; C) dressing, toileting, grooming, preference in bathing (e.g., bathing, showering, a.m./p.m.) and other personal care abilities; D) ambulation and transferring abilities; E) behavior triggers; effective calming approaches; and an analysis of each of the resident's patterns of dementia-related behaviors, such as wandering, agitation, anxiety, and safety issues; and F) adaptive equipment or activities that allow the resident to function at the highest practical level. 3) Assessments shall be conducted by a nurse, physical therapist, occupational therapist, social worker or unit director who has at least two years of experience working with residents with dementia and who has training in conducting behavioral or functional assessments. 4) The assessment process shall be ongoing by direct care staff or other professionals, as needed, and shall include the assessment components in subsection (a)(2). b) The care plan shall be developed by an interdisciplinary team within 21 days after the resident's admission to the unit or center. The interdisciplinary team shall include, at least, the attending physician, a nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, the resident, the resident's representative, and the certified nursing assistant (CNA) who is primarily responsible for this resident's direct care, or an alternate, if needed, to provide input and gain insight into the care plan. Others may participate at the discretion of the resident. 1) The care plan shall be ability centered in focus	F9999		

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F9999	Continued From page 14 (see Section 300.7030) and shall define how the identified abilities, strengths, interests, and preferences will be encouraged and used by addressing the resident's physical and mental well-being; dignity, choice, security, and safety; use of retained skills and abilities; use of adaptive equipment; socialization and interaction with others; communication, on whatever level possible (verbal and nonverbal); healthful rest; personal expression; ambulation and physical exercise; and meaningful work. 2) As new behaviors manifest, the behaviors shall be evaluated and addressed in the care plan. 3) The resident's care plan shall be reviewed by the unit director 30 and 60 days after the initial care plan's development and shall be modified, as needed, with the participation of the interdisciplinary team. 4) The care plan shall be reviewed at least quarterly. 5) All appropriate staff shall have access to and shall use the information in the care plan in order to integrate the care plan into the daily care of the resident. 6) The care plan shall be implemented and followed by staff who care for the resident. 7) Revisions may be made to the care plan at any time, with input from the resident, resident's family, and resident's representative, the care coordinator, and, if appropriate, the physician. 8) The resident and the resident's representative shall be given the opportunity to participate in care plan development and modification. If they are unable to attend, a copy or summary of the care plan or modifications shall be provided to the resident and resident's representative. c) The facility shall include the resident's family (	F9999		

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F9999	Continued From page 15 other than the resident's representative) in the interdisciplinary team and in care planning and shall provide information to the family about the resident and the resident's care plan, with the consent of the resident or, as appropriate, the resident's representative. d) When a resident is moved within the facility or different direct care staff are newly assigned, discharging and receiving staff shall communicate verbally and with written documentation to the newly assigned staff about the care plan and the needs of the resident. e) The unit shall have and follow a written plan for communicating information within departments, between shifts, between units, and with resident's family and resident's representative. f) The unit shall have a procedure that is implemented and monitored for safeguarding residents' adaptive equipment, such as hearing aids, glasses, dentures, and feeding and ambulation equipment. (Source: Added at 28 Ill. Reg. 14623, effective October 20, 2004)	F9999		