STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E147	A. BUILDING _____ B. WING _____	C 03/01/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBUS MANOR RES CARE HOME	**5107 21 WEST JACKSON BOULEVARD CHICAGO, IL 60644**

(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
F 324	Continued From page 7 should be filed with local police and physician notified. 16. Nursing must approve all residents who will be away from the facility for than four hours. 17. A pass is required for any resident who want to be away from the facility for more than 4 hours. 18. The Administer and Director of Nursing will be responsible to monitor all of the above.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS ASSOCIATED WITH COMPLAINT # 0680507 300.1010 h) 300.1210 a) 300.1210 b) 3) 300.1210 b) 6) 300.3100d)2) Section 300.1010 Medical Care Policies h) Facility staff shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for	F9999		

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F9999	Continued From page 8 Nursing and Personal Care a) 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 has been appointed for such individual (Section 1 -120 of the Act) b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 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. 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	F9999		

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F9999	Continued From page 9 that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3100 General Building Requirements d)2) All exterior doors shall be equipped with a signal that will alert that staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24-hour a day supervision of the door, a signal is not required. These regulations were not met based as on closed record reviews and staff interviews the facility failed to track a change in behavior for one resident (R1) who has a diagnosis of mental illness and had a recent reduction in psychotropic medications. The lack of assessment and monitoring of R1's mental and psychosocial well being led to R1 leaving the facility at approximately midnight on 2/2/06. R1 was subsequently found at the airport by the police and admitted to a hospital with the diagnosis of hypothermia, hyponatremia, hypokalemia and depression. Findings Include: Review of R1's clinical records shows R1 is a 45 year old male admitted to the facility on 8-3-95 with the diagnosis of schizophrenia, extrapyramidal syndrome, (EPS), and hypertension. Starting 1-11-06, the physician decreased R1's psychotropic medications. The change was from risperidone 4mg (antipsychotic medication) by mouth at bedtime to risperidone 3 mg by mouth at bedtime. Also benztropine 2mg	F9999		

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F9999	Continued From page 10	F9999		

by mouth twice a day was decreased to benztropine 1mg by mouth twice a day.

Nursing notes dated 2-2-06 at 12:00AM indicated R1 was not in the facility and facility failed to call police, notify family/MD, or take any action to search for the resident at this time. The next documentation in the nursing notes is dated 2-2-06 at 5:00PM and just states that R1 remains out of the facility and had no meds or meals. Nursing notes dated 2-2-06 at 8:50PM finally reveal an active search was implemented for R1 and at 9: 25PM the local police were notified and a missing person report was done. There is no documentation in the nursing notes or in the clinical records indicating that R1's physician was told of his inappropriate behavior 2 days prior to leaving the facility or that R1 had left the facility on 2-2-06.

Review of R1's hospital records document that R 1 was found roaming around a large airport and requested that the police take him to a hospital. R1 reported to the ER nurse that he felt suicidal thoughts and was noted to be shivering uncontrollably. R1's hospital records show R1 arrived at the emergency room on 2-2-06 at 2:25 AM with a core body temperature of 94.5 rectally, with hypothermia. R1 was confused and unable to answer any questions stating he is homeless. The facility had not made a missing persons report at this time to assist the police in locating the resident's current address.

Review of the facility's pass form for the resident shows R1 did not sign out of the facility on 2-2-06 . Review of R1's incident report dated 2-2-06 written at 8:50PM states, "R1 always signs out at

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the nursing station." This is under the comments section; steps taken to prevent recurrence.

Interview with E7 (Assistant Administer), on 2-10-06, E7 told surveyor the facility has a policy that all residents that leave the facility must sign out upon leaving and must sign in upon returning. E 7 also told surveyor R1 knows this policy and has done it many times.

Lab result taken in the emergency room reveals potassium level was 2.9, (norm 3.4 to 5.3), hypokalemia, sodium levels was 120, (norm 135 to 147), hyponatremia. R1 was admitted with a diagnosis of hypothermia, hyponatremia, hypokalemia and depression.

In a phone interview with Z2, (psychiatrist), on 2-10-06, Z2 told surveyor he lowered R1's psychotropic medications because R1 was doing much better. Z2 also told surveyor that he was unable to monitor and or evaluate the change in medication because the facility terminated him from facility. The facility sent him a letter stating he was no longer welcome in the facility and that his services were no longer needed. Z2 further told surveyor that the facility would not permit him on the premises after receiving his letter of termination to evaluate his current patients. At the time of the survey, facility reported that no other psychiatrist had been monitoring R1's med regime.

In an interview with E4, (social worker), on 2-10-06 at 1:50PM, E4 told surveyor R1's counselor noticed "a change in his behavior 1 to 2 days before." At the time R1 left the facility he was more confused and agitated. E4 also mentioned

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the recent med reduction which could alter R1's thought process, increase agitation, decrease in attention and concentration, and cause him to be not interested in his normal activities. E4 further went on to say R1 does leave the facility but only has done so with supervision because of his poor insight and has not left alone for long period of time.

Phone interview with Z3, (psychiatric physician), on 2-24-06 at 10:55AM, Z3 told surveyor he did not start to work at the facility until 2-06. Z3 told surveyor he did not see R1 until 2-20-06.

In an interview with E2 (nurse's aide), on 2-10-06 , E2 told surveyor R1 always has supervision when he leaves the building and does not leave alone. E2 also told surveyor she has never known R1 to leave and not come back in her 8 year's of employment at the facility. R1 would only go to the corner gas station which is directly across the street and come right back and never leave at night.

In an interview with Z1 (facility's pharmacisct),on 2-10-06 at 1:30PM, Z1 told surveyor it usually takes 4 to 6 weeks to see the true effects of psychotropic medication reduction. Ongoing monitoring of behavior to see the effects of the decrease of medication needs to be done.

Phone interview with Z2 on 2-24-06 at 10:30AM, Z2 further went on to tell surveyor no one in the facility told him of R1's inappropriate behaviors after the decrease in psychotropic medication. Z 2 also told surveyor that R1 has a long and chronic history of low sodium which also needed to be monitored coupled with the change in

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F9999	Continued From page 13 psychotropic medications, R1 needed to be monitored closely. Phone interview with E3 (Director of Nursing), on 2-24-06 at 10:25AM, E3 told surveyor R1 did not have a psychiatric physician after Z2 was terminated to evaluate and or assess R1's reaction to the change in medication. E3 further went on to say the first time R1 was seen by another psychiatric physician was 2-20-06, after R1 returned from an acute care hospital. The facility was aware of behavior changes and med reduction right before resident was found missing. When the nurse E5 was interviewed about why she failed to raise an alarm at midnight when the resident was found missing, she informed the surveyor that being gone was not unusual for this type of resident with mental illness, not taking into account that R1 was exhibiting mental changes and was missing at midnight which was not his usual behavior. The facility failed to search until approximately 20 hours later after R1 missed several meals and meds and failed to call police in a timely manner which hampered their investigation when resident was found at 2:25AM at 2-2-06. (A)	F9999		