STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145866	A. BUILDING _____ B. WING _____	C 02/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY NURSING PAVILION	**9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457**

(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 8 irregularities will be addressed immediately. 11. Staff will check all electronic monitoring devices and door alarms on a daily basis and keep a log. 12. The Quality Assurance Committee will review any incidents involving elopement and review measures that are being taken to prevent elopements for their effectiveness. 13. Administrator will monitor for overall compliance through his own rounds, general supervision and reports from Department heads.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS FOR COMPLAINT # 0690190 300.610 a) 300.1210 a) 300.1210 b) 6) Section 300.610 Resident Care Policies a) 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 thereunder . 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.	F9999		

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F9999	Continued From page 9 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 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: 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. These regulations were not met as evidenced by interview, record review and observation which determined that the facility failed to adequately supervise a confused resident (R2) identified at risk for elopement. The facility staff were not	F9999		

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F9999	Continued From page 10	F9999		

aware R2 left the facility unsupervised and unescorted at approximately 11:00 PM on 01/15/2006. R1 was found by the police at 11:38 PM in the 7900 block of 95th Street after responding to a call about "a man walking in traffic."

Findings include:

R2 is a 76 year old with diagnoses that include: dementia, head injury, hypertension, and drug and alcohol abuse. Review of R2's medical record (Nurses Notes, Monthly Summary) documents that R2 is alert, but confused. R2's assessment identifies R2's cognitive status is moderately impaired-decisions poor, cues/supervision required, and as easily distracted with periods of altered perception or awareness of surroundings.

R2's Elopement Risk Assessment Tool notes that R2 is confused to time and place, and has physical ability to leave the facility. R2 was to be placed on the Elopement Risk Prevention Program and a care plan developed. Some interventions that were to be included in the care plan were personal safety alarm devices, frequent monitoring, and that staff to be aware of resident's wander risk. R2's care plan notes that R2 demonstrates movement behavior that may be interpreted as wandering, pacing, or roaming related to confusion.

E4 (RN) stated during interview that she "arrived at the facility around 10:30 PM that night. Both the front and back doors were wide open. Neither door alarmed. They are supposed to be locked at 8:00 PM. I did the narcotic count with the 3-11 nurse, I then took the keys (key for

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F9999	Continued From page 11	F9999		

doors is kept with narcotic key)and locked both doors. The CNA (CNAs do the actual head count) notified me at 11:20 PM that R2 was not in his room. I notified the Administrator. The police department called at 11:40 PM to tell me that the resident had been found, and that he was being taken to the hospital for evaluation for hypothermia. I didn't have to call the police because they called me first. The Administrator was angry, he told me we should have looked everywhere for the resident and that we should have locked the doors."

E4 described R2 as confused, not completely aware of his surroundings, would wander up and down the hall. Per interviews with E2 (DON) and E3 (CNA), staff described R2 as confused. E3 and R1 (R2's roommate) both stated that R2 gets confused and cannot find his room requiring re-direction by staff/residents.

R2 admitted during interview to being "in a fog" and could not remember many details. R2 stated that he walked out the open back door of the facility, didn't know where he was going, and paramedics found him walking in the street. R2 appeared to be confused during interview. The surveyor had to show R2 how to get back to his room.

E3 stated that when she came into work that night, entering through the facility's back door, no alarm sounded. E3 stated that she began doing a head count at 11:09 PM and realized that R2 was not in his bed. E3 continued to make rounds and then returned to check the bathroom for R2 and noted he was not in the bathroom. E3 reported R2 missing to E4 (Charge Nurse).

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E1 stated that he supposed somehow during change of shifts as people were coming and leaving, alarms sounded and staff did not respond appropriately.

The Police report states that R2 was "staggering eastbound on 95th Street (95th is an extremely busy 4-lane thoroughfare with turning lanes in places). Subject was extremely disoriented and confused. Subject was cold to touch and only had a long sleeve thin cotton shirt on. A small hospital band with nursing home name on it upper right forearm." Police notified nursing home and was advised that they were unable to locate him. R2 was sent to hospital for evaluation.

Fire Department report dated 1/15 at 11:52 PM also confirms that R2 was confused, without a coat, cold to touch, difficulty walking, and about 1 mile from the facility. Paramedics treated R2 with hot packs and blankets, IV, oxygen at 2 liters and monitoring. R2 described as having" nasal secretions and drool all over his face that was hardened."

Surveyor called for weather information for the time the resident was missing; the outside temperatures were in the range of 35 degrees Fahrenheit at this time.

(A)