STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145473	A. BUILDING _____ B. WING _____	C 11/10/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTRE	**2330 WEST GALENA BOULEVARD AURORA, IL 60506**

(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 6 G. The facility security and safety plan and compliance with all of the elopement prevention plans is reviewed at the monthly CQI meeting...	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210(a) 3001210(b)(6) 300.1220(b)(2)(7) 300.3240(a) 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. 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.	F9999		

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F9999	Continued From page 7 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 7) Coordinating the care and services provided to residents in the nursing facility. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by : Based on Observation, Record Review, and Interview the facility failed to supervise a cognitively impaired resident who was sent to a nearby clinic by van transport, escorted to the reception area by the van driver, and then left unsupervised. (This resident has a history of wandering and wears and electronic monitoring device.) On 09/20/05 R1was left at the clinic unaccompanied by staff or family at about 10:00 am. R1 was found approximately four hours later on the clinic's front lawn.	F9999		

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F9999	Continued From page 8 This applies to one resident out of forty-three, who the facility has identified as being wanderers . Findings include: 1. R1's November 2005 Physician's Order Sheet (POS) documents R1 as an eighty year old resident. His diagnoses include Senile Dementia and a history of Schizophrenia with Agitation. His Resident Assessment Protocol dated 05/09/05 documents R1 as having short term memory problems and needs assistance with decision making. The resident has an electronic monitoring device in place due to confusion. R1 's Minimum Data Set (MDS) dated 08/01/05 assess R1 as having short term memory problems and being cognitively moderately impaired for daily decision making. His decisions are poor and supervision is required. This MDS also assesses R1 has no functional limitations and ambulates independently. The facility's ELOPEMENT RISK/ELECTRIC MONITORING ASSESSMENT TOOL dated 05/ 09/05 assesses R1 as an elopement risk and an electronic monitoring device was placed on his right wrist. R1's current Care Plan dated 08/02/ 05 documents a problem of decreased safety awareness secondary to periods of confusion and forgetfulness. Interventions for these problems include giving simple directions, redirect during periods of wandering, monitor for changes in behavior and thought process and remove resident from any area where the resident may be a threat to others during periods of increased confusion. On 10/20/05 at 10:35am R1 was interviewed regarding his clinic	F9999		

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F9999	Continued From page 9 appointment on 09/20/05. He stated that he could not remember that clinic visit. 2. On 10/20/05 between the hours of 09:30am and 03:00pm E1, the administrator, E2, the assistant administrator, E4, the assistant director of nursing, E6, a nurse, and E7, a nurse, were privately interviewed regarding R1's cognitive status and wandering behavior. All stated "R1 is cognitively impaired, has periods of confusion, has a history of wandering and requires supervision. He has poor safety awareness/ judgement and should not be unsupervised. Presently he has an electric monitoring device in place to prevent wandering out of the facility. E7 added that I am very familiar with R1. He often sits in the lounge near the front exit. About once a month he will attempt to exit the facility. He wants to catch the bus to go to the bank." 3. R1's Nursing Notes dated 06/04/05 document that R1 was spotted by a Certified Nursing Assistant (CNA) attempting to cross the street in front of the facility. ...R1 stated he was trying to catch the bus. The facility's initial investigative report dated 06/06/05 documented that R1 was allowed to go outside with another resident's family...they returned to the building without R1, leaving him unsupervised. R1 was then able to wander from the facility premises. The facility sign out logs were reviewed for 06/04/05. They failed to document R1 being signed out of the facility. The facility's policy for RESIDENT'S EXITING THE BUILDING documents that residents will be asked to sign out when leaving the building, either on or off the premises, and let nursing personnel know they are leaving. During an interview with E1 on 11/07/05 at 12:30pm it	F9999		

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F9999	Continued From page 10 was stated, " We have not been been having residents sign out when exiting the facility, if they are not leaving the premises. We will have to review this policy." On November 7, 2005 and 11:30am E3, a CNA on 06/04/05, stated she was on second floor of the facility. She happened to look out the window and saw R1 all the way across Galena Boulevard . She came down the stairs and met a nurse and a CNA. They proceeded to redirect R1 back to the facility. R1 told E3 that he was going to catch the bus. Galena Boulevard is a very busy road. It is four lane with a center median. The speed limit in front of the facility is 35 miles per hour. 4. On 10/20/05 E4 and E7 were privately and individually interviewed. Both stated outside clinic appointments are made. If family can not transport the resident to the scheduled appointment, transportation service is provided. When the transportation service is used, the driver is given paper work . This includes the residents' face sheet and physician orders. The driver also is given a card to give to the receptionist at the clinic. This receptionist is to call transportation, when the appointment is completed. The only documentation in R1's Nursing Notes for 09/20/05 reads that resident is out for Doctor's appointment, accompanied by ambulance services. (09:30am) Back from Doctor's appointment with orders. (R1 was transported to the clinic without facility staff or family supervision .) A facility investigation of the occurrence	F9999		

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F9999	Continued From page 11 documents that R1 had a 10:00am appointment. The clinic was unable to state what happened after the appointment. R1 was found in front of the clinic around 02:00pm. R1 stated, " It was such a beautiful day outside and I went to lay in the grass in the sun." On 11/07/05 at 12:00pm a phone conversation was conducted with Z1, R1's Physician. She stated that R1 does not recognize her from week to week. " He would not be safe alone on the street. He has no safety awareness; I would not give him enough judgement to cross a street. He needs cueing. He acts appropriate during examinations.... If R1 is in a clinic situation, I would expect either a family or facility staff to be with him at a clinic. I would not expect the clinic to supervise him." On 11/07/05 at 10:00am Z3, a clinic staff member, was interviewed regarding R1's clinic visit on 09/20/05. It was stated that R1 arrived in the clinic for a routine physician visit, accompanied by a transporter only. She added that R1's relative usually accompanies him to the clinic. R1 was in the examining room after the physician completed his examination. R1's behavior was appropriate during this time. He took his paperwork to the receptionist. R1 stated he had to use the washroom and then left the waiting room area. He was found in the grass in front of the clinic around 02:00pm. We do not know what happened in the interim. We then called the nursing home. We were not informed that R1 was a wanderer and needed close supervision. The clinic building is in a large medical complex.	F9999		