STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145958	A. BUILDING _____ B. WING _____	C 02/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HEALTH CARE & REHAB CT	**RESOURCE PARKWAY DEKALB, IL 60115**

(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 6. Door alarm drills to test the staff response to an episode of elopement will be done weekly. Effective 2/16/06 7. The Maintenance Director will coordinate test of all door alarms daily and codes to the front door will be changed each Wednesday. Effective 2/16/06. 8. Staff, families, and visitors will be reminded by a sign posted at the front door, not to share the door codes with residents. The facility newsletter going to all families next week will also address this. 9. Concerns will be discussed in the Quality Assurance Committee Meetings for resolution.	F 324		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a) 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. 300.1210b)4) Personal care shall be provided on a 24-hour, seven-day-week basis. 300.3100d)2) All exterior doors shall be equipped with a signal that will alert the staff if a	F9999		

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F9999	Continued From page 7 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 Based on observation, record review, and interview the facility failed to assure the safety of a resident with a history of elopement by failing to prevent the resident from leaving the facility alone. On 1/6/06 and 2/4/06 R1 left the facility on her own undetected by facility staff. R1 has poor judgment skills and was at risk for serious harm while being left alone. The findings include: This is for 1 of 4 residents at risk for elopement. (R1) Physician Order Sheet dated February, 2006 documents that R1's diagnoses include Cerebral Vascular Accident, Hypertension, History of Seizures, and Depression. R1's Minimum Data Set (MDS) Assessment dated 12/28/05 assessed R1 as having short and long term memory problems, moderately impaired cognitive skills for daily decision making, and insomnia. The elopement assessment for September, 2005 was reviewed and found to be partially incomplete. Nursing Notes dated 1/6/06 at 8:30 PM documents that "at some point in time R1 left the facility, the front door alarm was going off at 11:	F9999		

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F9999	Continued From page 8 00 PM. On 1/7/06 entry for 12:15 AM shows that R1 could not be found to receive scheduled midnight medications. At 1:05 AM documentation shows that the evening nurse left in her car to look for R1. It is documented that R1 was found walking on the edge of the road "no sidewalks at about 1:30 AM." On 2/15/06 at 1:05 AM E7 Registered Nurse (RN) said that she had worked the evening of 1/6/06. After her shift ended E7 drove her car to look for R1. E7 said R1 was found along the side of the road about 2:00 AM. "It was a dark area, there were no homes in that area at all." E7 said it was about 2:00 AM when she saw R1 along side the road. "It was a cold night, R1 was glad to see me. I asked her what she was doing way out here and R1 said I must have made a wrong turn." R1 was found on a road about 2.75 miles from the facility. E7 stated that often times toward the end of the shift she may be in a resident's room and may not hear the front door alarm, and by the time staff can get all the way to the front door, the resident may be gone. The temperature between the hours 8:30 PM on 1/6/06 and 2:00 AM on 1/7/06 ranged from 28.4 degrees Farenheit to 30.0 degrees Farenheit. (wunderground.com) On 2/14/06 at 2:00 PM E2, Director of Nursing (DON), said she was not aware that R1 had left the facility unassisted in January. The elopement Policy under section entitled: Procedures for Missing Residents and/or Elopements under item number 1 documents that staff should notify the Administrator and Director	F9999		

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of Nursing immediately.

Nursing Notes dated 2/4/06 at 12:30 AM document that R1 usually spent time in the front lounge. When the nurse went to the front lounge to look for R1 to give her medication, R1 could not be found. R1 was not found on the grounds of the facility. The notes show that a Certified Nursing Assistant was sent to drive and look for R1. R1 had walked to her daughter's house which is 2.3 miles from the facility.

The temperature on the night of 2/4/05 at 11:53 PM was 24.1 degrees Farenheit. (wunderground.com)

R1's care plan dated 11/15/05 through 2/15/06 does not address that R1 left the facility without staff knowledge on 1/6/06 and on 2/4/06. R1's care plan does not have any specific prevention interventions to ensure that R1 does not leave the facility again without staff knowledge. The care plan does not identify risk factors for R1 that place R1 at risk for leaving the facility unassisted.

History and Physical for R1 dated 11/9/05 documents that R1 needs to be in the facility where she can get direct observation and medication therapy. That may include assisted living or it may include permanent rehab placement.

R1's Psychiatric Consultation dated January, 20, 2006 documents that R1 was not oriented to the day or date, and that R1 had a belief that she is able to go home to care for herself and that this belief does approach delusional severity. R1's memory is moderately impaired, her judgement,

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F9999	Continued From page 10	F9999		

particularly regarding taking appropriate medication has been extremely poor. The same document shows that R1 has problems with calculations, memory and orientation, and is not capable of making decisions regarding her health care.

Z1 (Physician) was interviewed on 2/16/05 at 11:30 AM. Z1 was asked about R1 being out of the facility unassisted. Z1 said " She shouldn't be doing that , I don't know what else to tell you. R1 has a problem mostly with poor judgement. R1's judgement is so poor. R1 does have horribly severe cognitive problems, it really shows up in her judgement. It is dangerous for R1 to be walking around out there at night, she could walk into a corn field, I did give her a diagnosis of Dementia."

On 2/14/06 at 9:15 AM R1 was observed sitting on the side of her bed in her room. There were several plastic bags of belongings on the floor near R1's bed. R1's coat and scarf were lying on the end of her bed. R1's privacy curtain was pulled entirely around the bed. During R1's interview R1 stared straight ahead at the wall. R 1 was asked about leaving the facility and said she left because she wanted to. R1 said she "just played" with the front door alarm, then went out. R1 said " It was cold that night, and the blocks are really long. I was supposed to go home last week, they keep saying I am going home to my apartment." R1's verbal responses were delayed and hesitant.

R1 was interviewed again at 1:20 PM. R1 was asked how she would get to her daughter's house from the facility. R1 pointed and said "just

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F9999	Continued From page 11 go out here to that street, go right, then another street go right, no go left, then left, look for blue buildings." R1 was asked how she would cross the busy intersection and responded "Yeah, just go out there and make another turn at the light, make another turn then you are at the house where my daughter lives." During facility tour with E6 (Maintenance) on 2/14 /06 door alarms were tested. The South West exit door did not close completely after opening unless staff pulled it closed. E6 was interviewed on 2/14/06 at 9:00 AM and said that " the door alarms are tested periodically, about once a month I check them." The Resident Elopement Policy shows that: Residents who are at risk for elopement shall be provided at least one of the following safety precautions; door alarms on facility exits, a personal safety device, and staff supervision. The same document under item 5, documents that the door alarms will be checked for proper function on a weekly basis. (A)	F9999		