STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145868	A. BUILDING _____ B. WING _____	C 03/09/2006

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F 000	INITIAL COMMENTS INVESTIGATION OF COMPLAINT NUMBERS 0670541/IL21186 - NO DEFICIENCIES 0670627/IL21289 - NO DEFICIENCIES 0670474/IL21115 - F 324 A partial extended survey was conducted.	F 000		
F 324 SS=J	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by : I Based on Observation, Record Review,and Interview the facility failed to supervise a cognitively impaired resident who exited the facility unaccompanied by facility staff on 01/07/06 for fifteen to twenty minutes. The immediate jeopardy was identified on 03/01/06. R4 left the building after dark unaccompanied. R4 was found about fifteen to twenty minutes later in the middle of a busy road. The Immediate Jeopardy was identified on 3/1/06 .While Immediate Jeopardy was removed on 03/02/06 the facility remains out of compliance at a severity level 2 due to the need to evaluate the effectiveness of staff response to resident elopement. This applies to one resident (R4) out of five residents who the facility has identified as being wanderers.	F 324		4/9/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 324	Continued From page 1 Examples include: 1. R4's February 2006 Physician's Order Sheet (POS) documents R4 as an eighty-five year old resident. His diagnoses include Dementia, Dementia with Delusional Thought, Major Depression, and Pelvic and Back Fracture. His medications include Lexapro 5 milligrams (mg) daily, Zyprexa 5mg at bedtime, Abilify 5mg every morning, Namenda 10mg daily, and Celebrex 100mg daily. These medications are given to address his Dementia, Delusions, and Depression. R4's Minimum Data Set (MDS) quarterly dated 11/22/05 assessed R4 as having both long and short term memory problems. His cognitive skills for daily living are moderately impaired. His decisions are poor; cues/ supervision are required. R4 has no functional limitations in range of motion, but requires limited assistance of one person while ambulating. R4 also had a history of falling in the past 31 to 180 days. R4's Care Plan dated 2/20/06 (The current plan present in chart during the investigation) documents R4 is at a risk for falls. This is related to independent ambulation with a walker, but he forgets to use the walker at times. This is manifested by a history of falls that resulted in a pelvic fracture. R4 is also using psychotropic medication.. The approaches include to monitor the resident closely and to remind him to use the walker, and he is to be monitored while ambulating in the hallway and room. On 01/10/06 R4's Care Plan was updated with the problem that R4 is an identified wanderer with the potential for elopement risk and abuse due to being unaware of his surroundings. This is manifested by disorientation and confusion.	F 324		

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F 324	Continued From page 2 The resident stated," I never saw this place before" He wanders without a purpose and has stated, " I need to get out of here." He is unaware of his surroundings. Approaches include removing to a locked unit for his safety, and to be monitored for safety from abuse due to wandering. 2. R4's Nursing Notes document the following: a) 10/09/05 at 02:25pm. " Noted with episodes of delusions today. Resident came out to the front desk, claiming that he doesn't have a penny, he's broke and wanted to go home. Redirected and brought back to his room...Just repeats his dialog that he is broke and that he needs money to get home..." b) 01/05/06 at 03:20am. " resident noted to walk on the hallway in his nightgown, very agitated, unsteadily walking towards 200 unit living room, clutching his falling diaper...resident is very confused and claimed that it is the first time he has ever seen this place..." c) 01/07/06 at 01/07/06 at 07:21am. " resident has tendency to wander out. confused and disoriented. need to redirected to his room often. monitor of whereabouts. On 02/27/06 at 02:15pm E13 stated that R4 often refused Care depending on his mood. He liked to wander into other resident rooms..." 3. On 02/24/06 at 01:20pm R4 was sitting at bedside. He answered the surveyor's questions by referring to incidents in the past. He appeared confused. He did state," They won't let me go outside. I was a corporal in Italy during the war. I served as a guide and never got lost."	F 324		

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F 324	Continued From page 3 4. A facility Unusual Occurrence Report dated 01 /07/06 at 07:20pm documented, " the resident wandered off/eloped. Was found on the middle of a busy road. He was not able to cross the road when the Certified Nursing Assistants (CNA's) found him..." This report was reviewed by E2, the Director of Nursing (DON). During an interview on 02/24/06 at 02:00pm, E2 stated," I did not view this as an incident that required an investigation... The only thing we failed to do was follow R4 out the door." The facility did not present any further investigation or documentation of this incident. 5. On 01/07/06 at 10:17pm R4's Nursing Notes document," At around 07:20pm this Nurse heard a page from the reception desk saying 300 CNA to lobby emergency. This nurse went to the lobby and found out that the above resident had eloped/wandered out of the building.....All male CNAs went out for the search and it took 25 minutes to locate him.... he was found in the middle of a busy street." 6. The undated Elopement Policy -- Front desk documents that " if a resident should attempt to go outside unattended please notify the nursing staff immediately... the next course of action should be to leave the front area and stay with the resident outside until other staff can assist in returning the resident to the facility. It is important to stay with the resident...At no time should the resident be outside alone and never being outside a staff member's visual field." During a conversation with E1, the Administrator, it was stated that this policy was in effect prior to 01/07/06. At the time of the conversation, the date of origin of the policy could not be	F 324		

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F 324	Continued From page 4	F 324		

ascertained. On 03/01/06 at 12:00pm a phone interview was conducted with E4, a receptionist. She stated, " I was the receptionist on duty on 01/07/06. I saw a man outside.(R4) I went out and tried to get him to come back in....Another resident who was outside helped me to convince him to return. I went back in and paged for help .... I watched him from the window."

7. E9, E10, and E13 (CNA's who worked on 01/07/06) were interviewed over the phone. All stated that it was dark outside. All CNA's from the 300 wing responded to the report of a missing person. All agreed that it was dark outside and they had to find R4. E13 and E9 confirmed that R4 was walking on a busy road. E9 added that it took 10-15 minutes to find the resident. During a phone Interview with E12, a Registered Nurse, on 02/24/06 at 12:20pm , the Nursing Notes above were confirmed. However, E12 added that when the receptionist paged, the resident was already gone, and no staff member had followed him out. All those interviewed stated it was dark outside.

8. Z2, R4's physician, stated that the resident has dementia and is depressed. He also has paranoia. He has poor decision making skills and should not be alone outside the facility without supervision.

9. The facility is located .2 miles from a busy road on the east. The posted speed limit on the road is 45 miles per hour. Directly east of the facility parking lot is a hill sloping downward about 200 feet. At the bottom of this incline is a retention pond. There are no barriers around this pond. The busy road described above lies just

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F 324	Continued From page 5 beyond a gentle incline. On the South end of the facility is a another busy road. 10. The National Weather Bureau data for 01/07/06 recorded the weather at 07:00pm as being cloudy with a Temperature of 35 degrees Farenheit. Sunset was at 04:37pm. E1 was notified of the Immediate Jeopardy on 3/2/06 at... related to R4 leaving the building alone on 1/7/06 and the risk for his safety while he was gone. The surveyor confirmed the facility took the following actions to remove the immediate jeopardy: A. R4 was transferred to the secure unit on 01/07/06. B. All Nursing Staff and Receptionists were inserviced regarding the missing person policy. II. Based on Record Review and Interview the facility failed to provide proper assistive devices/ and or supervision to prevent bruising of one resident of 14 (R1) who require/required a mechanical lift for transfer.	F 324		

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F 324	Continued From page 6 Examples include: 1. R1's admitting Physician's Order Sheet documents R1 as an 86 year old resident with diagnoses that include Post Cerebral Vascular Accident (CVA) and Left Side Weakness. Medications include Sam-e 400milligrams (mg) two times a day, Sotalol 80mg every evening, and Armour Thyroid 60mg every morning. 2. R1's Nursing Notes dated 02/04/06 , 01:00pm documents bruising of the left upper arm and outer edge of the left breast. Occurred during the night on her left side. No Witnesses. The physician was notified. Family notified Continue to observe. 3. An Incident Report Investigation submitted to IDPH on 02/04/06 documented a new bruise with onset on 02/04/06 secondary to a mechanical lift squeezing during transfer. The location of the bruise was left outer breast, outer most aspect, armpit area. The lift was used per family request. " The resident is not a good candidate for the lift due to a flaccid left arm..... 4. A facility concern form dated 02/01/06 stated, " Have explained to the family that it is not like home. Family insists on using their mechanical lift and their methods, which take over 20 minutes to transfer the resident from bed to chair." 5. On 02/24/06 E2, the director of nursing, stated that the family was told that their lift was not appropriate. He added that the family insisted on staff using R1's personal lift. We did not write every thing down that occurred during	F 324		

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F 324	Continued From page 7 our multiple conversations. 6. R1's Current Care Plan dated 01/24/06 does not address R1's transfer using a mechanical lift. 7. R1's medical record fails to show documented assessments for which mechanical lift to use, other alternatives offered, or the family's response to these proposals. 8. On 02/24/06 at 12:45pm E15, a CNA stated the staff continued to use R1's lift for transferring, until R1 was transferred to the hospital on 02/04/06.. 9. At 10:40am on 03/02/06 E2 was asked why a Physical Therapy assessment was not done to determine appropriate transfer lifts and or techniques. He stated it was not done because the family refused to pay for this service.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.610a) 300.1210a) 300.1210b)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	F9999		

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F9999	Continued From page 8	F9999		

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.

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. Restorative measures shall include at a minimum the following procedures:

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.

Based on observation, record Review, and interview the facility failed to supervise a cognitively impaired resident who exited the facility unaccompanied by facility staff on 01/07/ 06 for fifteen to twenty minutes. This applies to one resident (R4) out of five residents who the

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F9999	Continued From page 9 facility has identified as being wanderers R4 was found in the middle of a busy road. Findings include: 1. R4's February 2006 Physician's Order Sheet (POS) documents R4 as an eighty-five year old resident. His diagnoses include Dementia, Dementia with Delusional Thought, Major Depression, and Pelvic and Back Fracture. His medications include Lexapro 5 milligrams (mg) daily, Zyprexa 5mg at bedtime, Abilify 5mg every morning, Namenda 10mg daily, and Celebrex 100mg daily. These medications are given to address his Dementia, Delusions, and Depression. R4's Minimum Data Set (MDS) quarterly dated 11/22/05 assessed R4 as having both long and short term memory problems. His cognitive skills for daily living are moderately impaired. His decisions are poor; cues/ supervision are required. R4 has no functional limitations in range of motion, but requires limited assistance of one person while ambulating. R4 also had a history of falling in the past 31 to 180 days. R4's Care Plan dated 2/20/06 (The current plan present in chart during the investigation) documents R4 is at a risk for falls. This is related to independent ambulation with a walker, but he forgets to use the walker at times. This is manifested by a history of falls that resulted in a pelvic fracture. R4 is also using psychotropic medication. The approaches include to monitor the resident closely and to remind him to use the walker, and he is to be monitored while ambulating in the hallway and room. On 01/10/06 R4's Care Plan was updated with the problem that R4 is an identified wanderer with the potential for elopement risk and abuse	F9999		

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F9999	Continued From page 10	F9999		

due to being unaware of his surroundings. This is manifested by disorientation and confusion. The resident stated, "I never saw this place before." He wanders without a purpose and has stated, "I need to get out of here." He is unaware of his surroundings. Approaches include removing to a locked unit for his safety, and to be monitored for safety from abuse due to wandering.

2. R4's Nursing Notes document the following:

a) 10/09/05 at 02:25pm. "Noted with episodes of delusions today. Resident came out to the front desk, claiming that he doesn't have a penny, he's broke and wanted to go home. Redirected and brought back to his room...Just repeats his dialog that he is broke and that he needs money to get home..."

b) 01/05/06 at 03:20am. " resident noted to walk on the hallway in his nightgown, very agitated, unsteadily walking towards 200 unit living room, clutching his falling diaper...resident is very confused and claimed that it is the first time he has ever seen this place..."

c) 01/07/06 at 01/07/06 at 07:21am. "resident has tendency to wander out. confused and disoriented. need to redirected to his room often. monitor of whereabouts.

On 02/27/06 at 02:15pm E13 stated that R4 often refused Care depending on his mood. He liked to wander into other resident rooms..."

3. On 02/24/06 at 01:20pm R4 was sitting at bedside. He answered the surveyor's questions

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by referring to incidents in the past. He appeared confused. He did state, "They won't let me go outside. I was a corporal in Italy during the war. I served as a guide and never got lost."

4. A facility Unusual Occurrence Report dated 01 /07/06 at 07:20pm documented, "the resident wandered off/eloped. Was found on the middle of a busy road. He was not able to cross the road when the Certified Nursing Assistants (CNA's) found him..." This report was reviewed by E2, the Director of Nursing (DON). During an interview on 02/24/06 at 02:00pm, E2 stated," I did not view this as an incident that required an investigation... The only thing we failed to do was follow R4 out the door." The facility did not present any further investigation or documentation of this incident.

5. On 01/07/06 at 10:17pm R4's Nursing Notes document, "At around 07:20pm this Nurse heard a page from the reception desk saying 300 CNA to lobby emergency. This nurse went to the lobby and found out that the above resident had eloped/wandered out of the building.....All male CNAs went out for the search and it took 25 minutes to locate him.... he was found in the middle of a busy street."

6. The undated Elopement Policy -- Front desk documents that "if a resident should attempt to go outside unattended please notify the nursing staff immediately... the next course of action should be to leave the front area and stay with the resident outside until other staff can assist in returning the resident to the facility. It is important to stay with the resident...At no time should the resident be outside alone and never being outside a staff

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member's visual field." During a conversation with E1, the Administrator, it was stated that this policy was in effect prior to 01/07/06. At the time of the conversation, the date of origin of the policy could not be ascertained. On 03/01/06 at 12:00pm a phone interview was conducted with E 4, a receptionist. She stated, "I was the receptionist on duty on 01/07/06. I saw a man outside (R4). I went out and tried to get him to come back in....Another resident who was outside helped me to convince him to return. I went back in and paged for help.... I watched him from the window."

7. E9, E10, and E13 (CNA's who worked on 01/07/06) were interviewed over the phone. All stated that it was dark outside. All CNA's from the 300 wing responded to the report of a missing person. All agreed that it was dark outside and they had to find R4. E13 and E9 confirmed that R4 was walking on a busy road. E9 added that it took 10-15 minutes to find the resident. During a phone Interview with E12, a Registered Nurse, on 02/24/06 at 12:20pm, the Nursing Notes above were confirmed. However, E12 added that when the receptionist paged, the resident was already gone, and no staff member had followed him out. All those interviewed stated it was dark outside.

8. Z2, R4's physician, stated that the resident has dementia and is depressed. He also has paranoia. He has poor decision making skills and should not be alone outside the facility without supervision.

9. The facility is located .2 miles from a busy road on the east. The posted speed limit on the

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ARLINGTON REHAB & LIVING CTR	**1666 CHECKER ROAD LONG GROVE, IL 60047**

(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
F9999	Continued From page 13 road is 45 miles per hour. Directly east of the facility parking lot is a hill sloping downward about 200 feet. At the bottom of this incline is a retention pond. There are no barriers around this pond. The busy road described above lies just beyond a gentle incline. On the South end of the facility is a another busy road. 10. The National Weather Bureau data for 01/07/06 recorded the weather at 07:00pm as being cloudy with a Temperature of 35 degrees Farenheit. Sunset was at 04:37pm. (A)	F9999		