STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145860	A. BUILDING _____ B. WING _____	R-C 03/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE NURSING HOME	9000 LA VERGNE AVENUE SKOKIE, IL 60077

(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 On 3/26 R4 will only have access to first floor with 1:1 supervision. On 3/28 an activity person was hired to start 3/29 /05 in order to engage and help supervise all wanderers in the building (approximately 7). .	{F 324}		
F9999	FINAL OBSERVATIONS STATE LICENSURE VIOLATIONS: 300.690a)1) 300.690a)2) 300.1210a) 300.1210b)6) 300.3100d)2) Section 300.690 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number. 2) A narrative summary of each accident or incident occurrence shall be sent to the	F9999		

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F9999	Continued From page 9 Department within seven days of the occurrence. 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. Section 300.3100 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the 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	F9999		

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F9999	Continued From page 10 required. These REGULATIONS are not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to adequately monitor and supervise one resident (R4) who was admitted to the facility on 1/31/06 with a history of confusion and eloping several times from another nursing facility. R4, who was identified as an elopement risk and was wearing an electronic monitoring device, left the facility unnoticed by staff on 02/22/06 at approximately 11:15 AM. Findings include: Review of the facility's incident reports found the following information documented: "February 22, 2006... Incident report is written today regarding resident ...(R4)... admitting diagnosis of Prostate Cancer. R4 is alert but confused... but independent with mobility and transfer. At 11:30 AM the CNA (certified nurses aide) in charge informed the Charge Nurse that she could not locate the resident in his room. She looked for him on the main floor but resident was nowhere to be found. ...At 11:45 AM Police report was done... At 1 PM, (R4) was brought back to the facility by the Skokie Police... Resident (R4) is alert and verbally responsive but cannot recall what happened." The National Weather Service states that for the time period that R4 was missing, the weather was 41 degrees at 11 AM, 43 degrees at 12 PM,	F9999		

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F9999	Continued From page 11 and 45 degrees at 1 PM. During the investigation (03/27/06 up to 03/28/06) several calls were made to contact the police officer (Z2) who received the facility's report that R4 was missing from the facility on 02/22/06. When Z2 called the surveyor and was interviewed by phone, Z2 stated, "They (facility staff) called us (the local police department) 1 1/2 to 2 hours after he (R4) was missing from the facility. We found him at a bank located at the intersection of Skokie Blvd. ....It's about approximately 2 miles from from the facility. ...I asked him where he was going? He said he was walking home. He (R4) was not wearing a coat. He had slippers on." On 03/22/06 at 2 PM, surveyor interviewed E3 in a conference room on the first floor of the facility. E3 was the CNA that was assigned to care for and monitor R4 on 02/02/06. E3 was unaware or not alerted when R4 eloped from the facility. E3 stated, "I was here the day that the resident (R4) left the building. I was his CNA. I went to shower another resident... When I came back, I couldn't find him. I went into every room. I tell the lady, she's a nurse with long hair. She (the nurse) said she saw him go down with the elevator. He had that bracelet on (electronic monitoring device). ... We could not find him. He (R4) had on blue shirt, pants white and blue stripes. Later, I saw when he (R4) came back at 12:30 PM or 1 PM, he was dressed with the same thing. No coat. He (R4) has a scrape to the knee. I think he (R4) had a fall. ...I'm surprised he got out. We cannot hear the alarm on the second floor." The nurse (E2) was interviewed on 03/22/06 at 3:	F9999		

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F9999	Continued From page 12 20 PM in a conference room on the first floor. E2 was also unaware of when R4 left the building. E 2 said, "It was the CNA who informed me at 10: 10 AM. We did room-to-room check. ...He (R4) came back at 1 PM or 2 PM. He came back with the police. He was wearing a shirt, pants, and shoes. We asked him (R4) where he had been. He (R4) said he was waiting for us and he had went with a lady. He (R4) had on the transponder (electronic monitoring device). ... The front door may have something wrong with it. We checked the transponder. It was working. ... I'm not sure he went out the front door." Surveyor also asked E2 to describe R4. E2 described R4 as a resident that wanders, confused at times, and unaware of his location. E1 (director of nursing) was interviewed on 03/22 /06. E1 reported that when staff reported to her that R4 was missing, she helped search for him but could not locate R4 in the building or the area surrounding the building. E1 also did not identify any staff member that observed or heard the electronic monitoring device alarm go off when R 4 left the facility. E1 said when the police returned R4 to the facility from the bank, R4 indicated to staff he was at the bank because he had money there. At 2:40 PM on 02/22/06, surveyor and E1 went to the main entrance front door and the door that staff identified as the ambulance entrance door. Facility could not identify for certain which of the doors the resident exited, but felt that he left either by the front door or with the ambulance drivers through the ambulance door. The ambulance door did have a sensor and if working, would have alerted the drivers that the	F9999		

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F9999	Continued From page 13	F9999		

resident had a monitoring device on. Surveyor observed as E1, holding a monitoring device, opened the doors. Each time, the alarm was not heard until the door was partially opened thus allowing the resident access through the door before alerting staff. The exit door in the kitchen area did not have an alarm sensor. Surveyor spoke to E8 (receptionist) who was on duty on 2/22/06 and reported that she heard no alarm and did not see the resident go out the front door. E8 felt that resident may have gone out the laundry door. The laundry door is a key lock and could not have been opened by the resident. E8 stated that she works only 8 AM to noon that day. Facility presented documentation that front door is staffed by receptionist until 6:30 PM and then a security guard takes over.

The facility is laid out with the nursing station on the second floor and offices, activities, and dining room/kitchen on the first floor. Residents come down for meals and activities. The alarm sounds at the door and at the second floor nursing station but requires that staff respond and go down to the first floor to investigate if alarm activated. Nursing staff are not in the station at all times and staff are not visually located at all the doors at all times that may have provided exit to R4. All staff interviewed denied hearing any alarm before or at the time R4 was missing.

During an interview by phone with E1 on 03/27/06 at 3:45 PM, E1 told surveyor that R4 may have exited with paramedics via the ambulance door on 02/22/06. However, E1 did not present any evidence to support this. And the facility was unsure how R4 actually eloped from the facility.

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F9999	Continued From page 14 At the time of the surveyor on-site visit, E1 did not have in place a plan that would address how the facility was going to give R4 the supervision and monitoring he needed. After the elopement, R4's plan of care only new intervention indicated that R4 would be checked for 15 minutes for 72 hours and gave no indication that other interventions were being revised/implemented to maintain R4 in the building. Because R4 is mobile, "looks normal" according to staff, and frequently goes to the first floor, supervision is a concern for this resident. E1 stated in the service plan dated 02/22/06 that R4 was now restricted to the second floor and only allowed on the first floor with 1:1 supervision . When surveyor pointed out to E1 that this new intervention was not reported as being done during staff interviews on-site or documented as a part of the resident's (R4's) plan of care, E1 re-submitted a second service plan dated 03/26/06 which added and stated "R4 will only have access to the first floor with one-on-one supervision." At a later meeting with administrative staff on 03/28/06, the facility also reported that they had hired a new employee to engage residents assessed as wanders/ elopement risk in activities during the day as a way to supervised these residents. Review of R4's clinical records indicate that R4 is 79 years old with Diagnosis including Prostate Cancer, Anemia, and Diabetes. R4's clinical record also contained an Transfer Note dated 01/ 31/06 which identified R4 having "History of Elopement a couple of times!" Review of R4's physician order sheet contained	F9999		

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F9999	Continued From page 15 orders for Risperdal 1 mg daily and Risperdal 1 mg at night. R4's MDS (Minimum Data Set) Assessment dated 02/09/06 assessed R4 as moderately impaired-"decisions making poor; cues/ supervision required." Review of R4's plan of care identified the following problems as a focus of R4's care with staff interventions for the following: "Impaired Short-Term Memory, Resident Is Forgetful," " Moderately Impaired Cognitive Skills For Daily Decision-Making Requires Cues/Supervision," " At Risk For Falls, Injury Due To Unsteady Gait, Impaired Safety Awareness, Uncooperative, Resisting Assist, On Psychotropic Medications, History of Wandering (Prior Admission)," and Resident Displays A Sad/Depressive or Anxious Agitated Mood." R4's plan of care identified that on 02/09/06 he was at risk for elopement. Some of the interventions were not appropriate for a resident who the facility assessed as being forgetful, needing assistance with Activities of Daily Living, and who is cognitively impaired. Interventions for R4 such as: (6) "Instruct Resident to ask staff for guidance whenever gets lost. (10) ...Advise/Remind to ask for assistance, and to notify staff any time when wants to leave the facility." When the interventions for this problem were found to be ineffective on 02/22/06, the only new staff intervention implemented as a response to the elopement was to monitored R4 every 15	F9999		

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F9999	Continued From page 16 minutes for 72 hours. There is no evidence of the facility reporting E4's elopement or the corrective actions done on 02/22/06 to the state regulatory agency. The Illinois Department of Public Health (IDPH) regional office's log book of reported incidents was reviewed on 03/27/06 and 03/28/06. The regional log book contained no documentation of receiving any reports from the facility regarding R 4's elopement on 02/22/06. On 03/27/06, surveyor asked E1 to provide evidence that a report was sent to IDPH. E1 told surveyor she did not send the report but someone in her office had, and she would present the evidence later. Up to date of exit on 03/28/06, E1 did not provide the surveyor with the requested information. (A)	F9999		