STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E836	A. BUILDING _____ B. WING _____	C 01/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT NURSING HOME	**1936 WEST BELMONT AVENUE CHICAGO, IL 60657**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 2 E1 was interviewed again via phone on 1/22/07. E1 stated that the person she talked to at R 3's previous facility said the police had brought R3 to the hospital. The police had found R3 on the street. R3 was confused and disoriented. R3 was taken to the hospital (11/13/06). The hospital called R3's previous nursing home and asked if R3 was their resident. The police took R3 to the hospital as a routine measure. E3 (Nurse) was interviewed via phone on 1/22/07. E3 stated the following: "R3 had attempted to run out of the facility on three (3) separate occasions on 11/12/06" R3 wanted to leave the facility. She did not want to be there. (This was also noted in nurses notes of R3's medical record). E3 stated in her notes that R3 had to be monitored for elopement. Facility staff for the next shift were suppose to know that "R3 was an elopement risk". E3 stated that in her opinion, "R3 should never have been admitted to the facility". E1 was notified of the Immediate Jeopardy on 1/23/07 at 9:30 a.m. The facility removed the immediacy on 11/13/2006 when R3 was discharged from the facility. The facility remains out of compliance at a severity level 2.	F 324		
F9999	FINAL OBSERVATIONS STATE LICENSURE VIOLATION	F9999		

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F9999	Continued From page 3 STATE LICENSURE VIOLATION 300.1210a) 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. This REGULATION is not met as evidenced by: Based on record review, employee interviews, and interview with E1, the facility failed to supervise one recently admitted resident (R3) who was identified as an elopement risk. Findings include: R3 was admitted on 11/07/06 with a diagnosis that included Schizo-Affective Disorder. There was no assessment initiated with the resident to determine if she was capable of living in the facility. R3 had no MDS (Minimum Data Set) or Care Plan in her medical record when it was reviewed by surveyor. R3's nurses notes were reviewed, and the following information was noted:	F9999		

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F9999	Continued From page 4 On 11/7/06, R3 was found wearing her roommate's clothing. On 11/8/06, nurses notes reflect that R3 was withdrawn and isolative. R3 refused to eat meals and refused to take medications. On 11/12/06 at 10:00 a.m., R3 ran out of the facility but was brought back by two staff. The notes then reflect that R3 was to be closely monitored for elopement. On 11/12/06 at approximately 5:50 p.m., R3 left the facility. Facility staff went out to look for R3 but failed to locate R3. Police were notified by facility staff. The staff failed to prevent R3 from leaving the facility. Staff interviews reveal that no one actually saw R3 leave the facility. When E4 went to pass medications, R3 was gone. E1 (Administrator) was interviewed on 1/19/07. During the interview E1 stated that she "talks to everyone" (staff) to see if the resident is capable of living in the facility prior to any resident being admitted. E1 said that Z1 stated that R3 could live in the facility. E1 stated that this facility does not admit residents that are not capable of going out in the community. The facility does not have any system to supervise residents who go out in the community. The doors are secured at 10:00 p.m. and opened at 7 A.M.. There is a sign-out sheet for the residents to sign out prior to leaving the facility. E1 stated that the facility found out that R3 was in the hospital when R3's previous nursing home contacted the facility to report that they had received a call from the hospital alerting them that R3 was in the hospital. E1 was interviewed again via phone on 1/22/07.	F9999		

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F9999	Continued From page 5 E1 stated that the person she talked to at R3's previous facility said the police had brought R3 to the hospital. The police had found R3 on the street. R3 was confused and disoriented. R3 was taken to the hospital (11/13/06). The hospital called R3's previous nursing home and asked if R3 was their resident. The police took R3 to the hospital as a routine measure. E3 (Nurse) was interviewed via phone on 1/22/07. E3 stated the following: "R3 had attempted to run out of the facility on three (3) separate occasions on 11/12/06." R3 wanted to leave the facility. She did not want to be there. (This was also noted in nurses notes in R3's medical record). E3 stated in her notes that R3 had to be monitored for elopement. Facility staff for the next shift were suppose to know that "R3 was an elopement risk." E3 stated that in her opinion, "R3 should never have been admitted to the facility." (A)	F9999		