STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145180	A. BUILDING _____ B. WING _____	C 03/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVIERA MANOR	**490 WEST 16TH PLACE CHICAGO HEIGHTS, IL 60411**

(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 9 activated correctly, staff are making rounds, signs and resident list remain posted. These checklist will be presented and reviewed by the QA Committee. The Assistant Administrator will conduct a monthly QA checklist after the four weeks to ensure compliance. Additional training will be provided if needed.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.690a) 300.690a)1) 300.690a)2) 300.690b) 300.1210a 300.1210b)4) 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 10 Department within seven days of the occurrence. b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurse's notes for each resident involved. 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 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. b)4) Personal care shall be provided on a 24-hour, seven-day-week basis. 300.3100 General Building Requirements d)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 required. These requirements were not met as evidenced by the following: Based on record review, interviews and observations, the facility failed to supervise and prevent one (R2) of 3 residents identified with the behavior of wandering, from leaving the facility	F9999		

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F9999	Continued From page 11 unsupervised and inappropriately dressed for inclement weather out of an exit door that is supposed to be alarmed. R2 has diagnoses including dementia with behavior disturbance and depression. R2 also has documented history of wandering throughout the facility and needing to be redirected. R2 was found outside of the facility without appropriate outerwear (hat, coat, gloves and shoes) and with his hands on the chain link fence. Review of the local weather reports for 2/3/07 indicates a high of 13 degrees Farenheit and a low of 1 degree below zero. Findings include: Review of R2's clinical record shows R2 is a 65 year old resident with several diagnoses including Dementia with behavior disturbance and Depression. R2 was admitted to the facility on 8/6/2003. R2 is identified as having several behaviors including Pica (eating or mouthing objectives other than food) and wandering throughout the facility. R2 is nonverbal except for moaning or groaning. R2 relies on staff for all ADL's (activities of daily living). During interview on 3/13/07 at 10:55am E3 (psychiatric rehab director) stated, "R2 doesn't go to a day program. R2 is so low cognitively, R2 wouldn't benefit from it. R2 has dementia. R2 doesn't go out to the community. R2 is a wanderer because of R2's cognitive level, he doesn't go out." Review of the incident report filled out by E7 (nurse) dated 2/3/07 at 4:30pm documents the following:	F9999		

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F9999	Continued From page 12 Received alert, disoriented with confusion upon rounds, left hand edema noted with blister. Ambulatory status: independent Mental status: alert, confused, disoriented. Description of Incident: received alert and disoriented with confusion. Upon rounds, left hand edema noted with blister. R2's physician was notified and gave orders for Tylenol 500mg 1-2 tablets every 4-6 hours as needed and an X-ray of the left hand. The recommendations for prevention of similar occurrences: continue to monitor the resident frequently. Further review of this incident report did not explain what may have happened causing this injury to R2's left hand. Review of the nurse's notes dated 2/3/07 at 4:30pm documents, "received alert, disoriented time 3 with confusion. Left hand severe edema noted. Painful when touched." The nurse's note shows R2 was given Tylenol 500mg, 2 tablets. Per interview with E2 (director of nursing) on 3/14/07, the incident report was not sent in to state agency but an investigation was completed. When surveyor asked to see the investigation, E2 was not able to present it to the surveyor. During telephone interview on 3/14/07 at 1:35pm, E7 (nurse) stated, "It was a bad weather day. Not snowing but very, very cold. I got there at about 4:00pm. I had R2 on the 3pm to 11pm shift. As I was walking down the hall to Station I, one of the CNAs (certified nurse aide) came to me and asked me to look at R2's hand. It startled me. I asked her what happened? I said that because	F9999		

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F9999	Continued From page 13	F9999		

the hand wasn't like that the day before. I remember because I always take R2 by the hand and walk with R2 to redirect him." E7 further stated, "the left hand was very swollen. The digits and the whole hand, up to the wrist, the part where one would wear a watch. When I touched it, it wasn't cold, but it wasn't warm either. R2 acted like it was painful." E7 went on to say that there was nothing documented in the chart on the day shift indicating what may have happened to R7's left hand. E7 also said there was nothing documented on the 24 hour report sheet.

Review of the 24 hour report sheet dated 2/3/07 day shift, did not show any documentation about R2 wandering outside or an assessment of the left hand.

Further review of the nurse's notes does not show documentation for 2/3/07 during the 7am-3pm shift. The nursing entry dated 2/4/07 at 2:00am shows R2's hand was observed with blisters. R2's physician was paged. At 7:58am R2 was transferred via ambulance to the hospital.

During telephone interview on 3/15/07 at 3:35pm, E10 (CNA) stated, "when I encountered him (2/3/07), it was after 3:00pm. R2 was sitting on the bed. I was getting him out of the bed to check his diaper. R2 acted like he didn't want me to touch him. I lifted R2's arm, that's when I saw the hand. I noticed the hand was disfigured. It didn't look right. It was very swollen. I told the nurse." E10 went on to say that R2 is a wanderer. R2 has been seen standing by the door, but doesn't try to get out."

Review of the hospital H&P (history and physical) dated 2/4/07 shows the following:

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F9999	Continued From page 14 R2 was sent from the nursing home with a complaint of acute discomfort of the left hand with edema and a blister formation. Upon arrival to the emergency room, R2 was noted to have significant swelling of the left hand with associated blister formation. R2's x-ray did reveal severe soft tissue injury around the fifth metacarpophalangeal joint with tiny bony fragments ...the fingers are very dusky in appearance. Review of the Orthopedic notes dated 2/5/07, at 5:20pm, documents: swelling and bullae (blisters) of left hand, bluish discoloration of fingers. Exam consistent with frostbite. Medicine notes dated 2/5/07 also, documented "left hand swelling/bullae/frostbite, cellulitis." During telephone interview on 3/13/07 at 2:55pm, Z1 read the treatment notes to surveyor. Surveyor asked Z1 what was R2's official diagnosis. Z1 stated, "the diagnoses for R2 were burns from frostbite." During telephone interview on 3/16/07 at 8:30am, Z3 stated, "I dictated a consult on that patient. I stand by what I wrote." During direct observation on 3/14/07 on Station I surveyor was accompanied by E2 (director of nursing) and E6 (CNA supervisor). At 10:00am, R2 was noted seated in a chair next to the nurse's station. R2's left hand was noted to be swollen. The 2nd through 5th fingers were swollen and pink from the 2nd joint down to the finger tips. The 2nd finger and nail on the right hand was noted to be dark in pigmentation with a small amount of peeling skin.	F9999		

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F9999	Continued From page 15 During interview at 10:10am E5 (nurse) stated, "R2 is total care. R2 doesn't do anything for himself." During interview at 10:15am E6 stated, "R2 needs assistance with all ADLs (activities of daily living). R2 is a wanderer. R2 goes in a out of other resident's rooms." Surveyor asked E6 if it was possible for R2 to have wandered outside on 2/3/07. E6 stated, "I was here that day (2/3/07)...during the afternoon. R2 just opened the door (leading to the outside). The alarm went off. The behavior aide and the CNA went out to get R2. R2 didn't have a coat on. R2 wasn't out there long. As soon as the alarm went off, they got R2 and brought him back in." During this interview, E6 identified who the CNA was (E9). E9 was out of town on vacation and unavailable for interview. Review of the CNA staffing sheet dated 2/3/07 indicates E6 was scheduled to work the 3pm - 11pm shift. While interviewing E5 and E6 in the Station I hallway, surveyor noted several residents and a staff person come in and go out of the glass door to the outside. Surveyor did not note an alarm go off when the door was opened. Surveyor asked E6 about the door and where it led to. E6 stated, "that door leads to the outside patio and sitting a area." Surveyor and E6 went outside the glass double door. The alarm did not sound. Several residents were noted on the patio as well as in the sitting area on the east side of the building. During a confidential telephone interview on 3/14/07 Z2 stated, "I have no idea how R2 got out	F9999		

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F9999	Continued From page 16 there (court yard). The behavior aides job is to patrol the building and intervene when needed. They aren't assigned to one spot." Z2 further, stated, "That's why R2 was spotted. R2 looked like he was trying to hop over the fence but is too weak. It was freezing cold outside. I don't know how long R2 was out there. R2 had to be out there for at least 20 minutes. R2's body was very cold. No, R2 didn't have a coat or shoes on. R2 had BM'd (bowel movement) on himself. I was afraid to touch R2 but it was cold and we needed to go back in. I don't remember who the nurse was because I left after R2 was brought in so he could be cleaned up. The door alarm wasn't on." Surveyor asked if the door alarm is ever on. Z2 stated, "yes the door usually has an alarm on it. But some people go in and out to smoke so the alarm is turned off so they don't have to keep turning it off and on. When I saw R2, the door wasn't alarmed." Reveiw of R2's clinical record lacked documentation of a nurse's entry of an assessment on R2 after being brought in from outside. Per interview with E2, E8 the nurse on duty during the day shift on 2/3/07 is no longer employed at the facility. No phone number was available for contact. During interview on 3/14/07 at 4:50pm, surveyor asked E1 to see where the alarm system was located and about the operation of it for the two doors. Surveyor and E1 walked to the Station II nurse's station. The small white control panel was located on a wall in the back of the station. A red light was on. E1 stated, "the red light has to	F9999		

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F9999	Continued From page 17 be on. If it's not on, the system is not on. If the alarm was off, it would read on the front of the panel "system bypass." E1 then took surveyor through the activity room to the patio. This door was not alarmed. Several residents were on the patio. There is a walk way that leads to the Station I door. The station I door is approximately 11 steps from the chain link fence. The back part of the facility's building is enclosed with a chain link fence. Surveyor asked E1 if this was the area where R2 was found on 2/3/07 during the 7am - 3pm shift (exact time was not documented. Interviews did not idicate the exact time R2 was found on 2/3/07). E1 stated, "yes." Surveyor also noted the handle on the left door was missing. Surveyor asked if he was aware of how long the handle had been missing. E1 stated, "I don't know. I don't even know if maintenance is aware of this." Surveyor wanted to know when the Station I and Activity doors are locked. E1 stated, "the doors to Station I and the activity room are alarmed, but not locked. Only the front entrance door is locked with a key in the evening." Base on a review of the facility's list of full/part time employees representing all departments, a total of 158 are employed at the facility and have access to both of these doors. (A)	F9999		