STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145336	A. BUILDING _____ B. WING _____	03/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR PAVILION	66 WEST OAK STREET CHICAGO, IL 60610

(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 13 8. The Administrator will monitor compliance with the revised program, including maintaining copies of logs and education records. Random audits of complaints with the electronic alert sysytem will be completed weekly.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210 a) 300.1210 b)3) 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) General nursing care shall include at a minimum, the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements are not met as evidenced by:	F9999		

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F9999	Continued From page 14 Based on observation, record review and interviews, the facility failed to adequately supervise 1 of 1 sampled residents (R18) with current diagnoses including Alzheimer's Disease and Organic Brain Syndrome and who currently resides on the locked Alzheimer's unit. R18 was previously identified as being at high risk for elopement, and the facility failed to adequately monitor the doors and elevators on 03/03/07, in order to prevent R18 from leaving the building. Findings include: During a review of the incident log on 03/21/07 an entry was noted that stated that on 03/03/07 at 5:00pm R18 eloped from the facility. The corresponding interdisciplinary progress notes read that the police notified the supervisor at 6:10pm that they (police) found R18 walking down Michigan Avenue with no coat on. The note goes on to say that according to the front desk the electronic alert system did not go off because she (E9/receptionist) did not hear any alarm. When R18 returned, the electronic alert system set off the alarm when she (R18) went in the second doorway near the hall. The physician's (Z1's) progress notes of 03/03/07 read, in part, as follows: "Called by nurse (E11) States patient (R18) wandered away from the facility at 5:00pm-despite electronic alert system and coded elevator. Found by CPD (Chicago Police Department) wandering on Michigan Avenue without a coat. No evidence of trauma. Will need further surveillance intervention to prevent recurrence." A check of AccuWeather.Com reflects that the	F9999		

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F9999	Continued From page 15 high temperature on 03/03/07 was 27 degrees Farenheit, and the low was 21 degrees Farenheit. On 03/04/07 at 1:00pm, R18 was noted to be limping on the right side while walking. A physician order was obtained for an x-ray of the right foot/right ankle and bilateral hip and pelvis. The results were negative. Review of R18's medical record indicates that R18 is 86 years old and has Alzheimer's Disease and Organic Brain Syndrome, short and long term memory problems, supervision is required with decision making, wanders, takes antipsychotic medication, and reorientation such as cueing is necessary. R18's care plan entry dated 12/18/06 indicates that R18 is at risk for falls. R18's care plan entry of 12/18/06 also indicates that the resident is at risk for elopement, requires redirection when wandering and is provided with an electronic alert system. R18's care plan of 12/18/06 also indicates the resident has a progressive alteration in cognition functioning and memory, a decreased ability to comprehend directions and impaired decision making, and needs an explanation of all procedures, requests, in simple terms. A review of R18's nurse's notes/interdisciplinary progress notes of 08/20/06 at 1:10pm reads, in part: "Resident left the floor and resident got on the elevator with family member and went down to lobby. Redirected her (R18) to the dining room on the 6th floor. Elopement monitoring initiated, continue close monitoring." 10/20/06 note of 9:20pm reads, "Resident alert; responsive, confusion noted. Wanders around the unit, can be redirected."	F9999		

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F9999	Continued From page 16 Review of R18's MDS (Minimum Data Set) of 09/14/06 reflects that R18 is scored a "2" for cognition, indicating that R18 is moderately impaired for daily decision-making. The MDS also reflects that R2 has a memory problem, and the behavior of wandering. On 03/21/07 at 2:50pm, R18 was observed seated in a chair during an activity group on the Alzheimer's unit. Surveyor and R18 went to the resident's room, and surveyor asked R18 about leaving the unit on 03/03/07. R18 stated, "I have no idea what happened, they probably talked to me about it, but I don't remember." As the conversation continued, R18 repeated the above statement, was confused and became agitated. Surveyor then terminated the interview. Surveyor then interviewed E11 (nurse on duty at time of the 03/03/07 elopement incident) at 3:05pm on 03/21/07 about what happened that day. E11 stated, "She (R18) is very confused, disoriented and cannot remember, she is dementia. I was the nurse at the time she (R18) left the unit around 5:00pm on a Saturday. R18 asked E10 (CNA/certified nurse assistant) to go to the bathroom. E10 accompanied her (R18) to the shower door, then left to go back to the dining room. Three minutes later, he (E10) goes back to the shower room door and knocks, and found that R18 wasn't there. Past 6:00pm, the police brought her (R18) back. They found her along Michigan Avenue walking without a coat and it was cold. The police wondered why was there a lady walking without a coat. Z1 (physician) came at 11:00pm on Saturday night and examined her (R18). I found her (R18) hands felt cold, circulation was ok. No, she (R18) didn't	F9999		

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F9999	Continued From page 17 go to the hospital. E10 was in the day room alone as staff. She (R18) had an electronic alert system on, she (R18) had to have gone out of the front door. But, at that time, according to the receptionist, the electronic alert sysytem didn't go off. I don't have a clue how she (R18) got off the unit. Then E11 and surveyor briefly toured the unit (6th floor) testing the coded elevator and the door alarms on 3/21/07. The northwest door when pushed and opened by E11, did not alarm as it is designed to do. E11 stated, "I didn't know the door wasn't working." E11 summoned maintenance to evaluate the problem. On 03/22/07, the facility presented the team with a work order from Z2 (alarm repair) stating the following: "Adjusted plate to allow egress sensor to trip when egress attempted was extremely difficult to start egress cycle." The facility failed to monitor the doors after R18 eloped from the building and surveyor found a means of egress when investigating the incident weeks later. During the interview with E10 (CNA) at 3:25pm a on 03/21/07, E10 stated, "I was watching her (R18) that day, she (R18) had an electronic alert system on her (R18) left wrist. She (R18) was an elopement precaution, she (R18) has tried to leave the unit before. She goes to either elevator, she put her hands over the buttons where the codes are. She presses it sometimes, most of the time it doesn't open. She (R18) got up and went to the shower room to use the toilet. I saw her (R18) go in there. I (E10) went back later to the shower room, and R18 was gone. E11 was by the dining room setting up her medication. This is across from the shower room where R18 was. I checked the unit and couldn't find her (R18). I	F9999		

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F9999	Continued From page 18 immediately notified the nurse when I didn't see her (R18 in the shower room or activity room.) The police did return her (R18) about 6:00pm, it was cold that day. I'm thinking she (R18) might have gotten on the freight elevator if someone accidentally pushed the elevator from the inside. She (R18) didn't have a coat on her, she was found on Michigan Avenue." Several attempts to interview E9 (receptionist) were unsuccessful. However, on 03/22/07 a review of E9's written statement dated 03/03/07 reads, "When R18 left, I didn't hear the beeper go off. Tonight was the first time I (E9) saw her (R18). I had no knowledge of a photo book for the residents that wander." E9 received a formal disciplinary action, as a result of the incident, for failing to follow work policy and procedure for resident care established by the facility. On 03/22/07 at 3:25pm during a review of the 03/03/07 incident file, it was noted that E12 (nurse) received a formal disciplinary action on 03/05/07 related to a 03/01/07 incident involving R18. The reason for the action is, "failure to report an elopement of a resident (R18) off the unit." To get more details about the action, surveyor interviewed E13 (Avalon Coordinator/6th Floor Alzheimer's Unit) on 03/22/07 at 3:25pm. E13 stated, "The nurse informed me that on 03/01/07, that she (E12) found R18 on the elevator, and brought her (R18) back to the floor and didnt report this. She (R18) has been on elopement precautions since at least the last year." (A)	F9999		