STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145764	A. BUILDING _____ B. WING _____	C 09/06/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTED TERRACE NURSING CTR	10935 SOUTH HALSTED STREET CHICAGO, IL 60628

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F 332	Continued From page 13 ~~by E16 and as documented in MAR (Medication Assessment Record).~~	F 332		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b)3) 300.1210b)6) 300.3100d)2) 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 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 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	F9999		

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F9999	Continued From page 14	F9999		

made
by nursing staff and recorded in the resident's
medical record.
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)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:

Based on observation, interview and record review, the facility failed to adequately supervise R8 and R13.

R13, who suffers from Alzheimer's Disease and is a known elopement risk, left the facility, 8/21/07. The resident walked over 1 mile, crossing railroad tracks and well traveled intersections before being seen by an off duty facility employee who alerted staff of his absence.

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F9999	Continued From page 15	F9999		

R8 suffers from Alzheimer's Disease which has manifested itself in a known aggressive behavior toward other residents (e.g.. R13) and staff. R8's aggression was allowed to escalate over a two month period (June 07/July 07) from verbal abuse to physical abuse against R13 without staff intervention (behavioral re-assessment or drug regimn changes). The final result of R8's escalating behavior was R13 being sent to the hospital with a hematoma after R8 hit R13 with a television.

- The facility has continued to leave R13 in harms way by not either removing R8 or R13 from resident room 330.
- The facility has only responded to R8 escalating aggressive behavior by giving the resident medication after he has abused residents and staff members. No effort has been made to re-assess the approaches on his care plan or determine what was causing his behaviors in to reduce or stop the abuse.
- The facility allowed R13 to elopement by not following the resident's care plan which calls for tracking sheet and monitoring elevators and exit doors.
- R13's electronic monitoring bracelet is on his wrist, making it easy for the resident to take off.
- The facility did not re-assess other elopement risk residents before prompting by the complaint.

Findings Include:

1) R13 has a diagnosis of Alzheimer's, Dementia, Anemia, Diabetes, Psoriasis, Hyperlipidemia, Organic Brain Syndrome and Benign Prostatic Hypertrophy. On 8/21/07, R13 eloped from the facility. The resident walked

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F9999	Continued From page 16	F9999		

approximately 1.2 miles before being taken to the hospital bleeding profusely from a head injury.

E10 was interviewed by telephone, 8/31/07 at approximately 1:40pm, concerning R13's elopement from the facility. E10 stated that 8/21/07 at about 2:30pm, she was driving to work on 111th street when she saw R13 walking toward the hospital located at 45 West 111th Street. The resident was just about to cross the railroad tracks between Steward and Princeton. E10 got out of her car and tried to coax R13 into her car. R13 became aggressive and refused to get into the car. E10 called the facility and spoke to E11 (Receptionist) and E1 (Administrator). E1 told E10 to continue to follow R13 until they arrive. R13 continued walking east on 111th toward the hospital. At Wentworth and 111th, construction workers were working on a new Condominium Complex. R13 tried to go around them but fell. E10 called the facility again and spoke to E1 because now R13 was bleeding profusely from the head. E1 told E10 to call "911." The Fire Department came and took R13 to the hospital before E12 (Director of the Alzheimer's Unit) arrived on the scene. E10 said that the Fire Department arrived at 2:45pm. E10 was asked if the resident was aware of his surroundings. E10 stated, "R13 was not walking safely. He never watched for cars when crossing street or looked for a train when he walked across the tracks."

E12 was interviewed, 8/30/07 at approximately 11:00am in the hallway of the 3rd floor concerning R13's elopement. E12 stated that the resident probably got on the elevators with some visitors because the exit doors on the 3rd floor did not alarm. The resident rode the elevator down to the

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F9999	Continued From page 17	F9999		

1st floor and walked out of the building with the visitors. A note written in R13's clinical record states that a maintenance worker noticed an exterior door alarm going off. The note did not state the location of the alarm. E12 clarified the statement by saying that R13's electronic monitoring bracelet tripped the alarm at the 1st floor front exterior door. The individual monitoring devices are not set off at the exits on the 3rd floor where R13 resides. The individual electronic monitoring devices are set to alarm at exterior doors leaving the building. E12 further stated that he is responsible for checking the monitors of each of the residents wearing them. "I check them weekly."

E11 (Receptionist) was interviewed 9/4/07 at approximately 4:30pm at the 1st floor front Receptionist desk. E11 stated that the alarm for individual monitoring devices goes off if a resident tries to exit one of the exterior doors. The alarm can be heard throughout the 1st floor. She could not say if it is heard on any of the other floors. E11 was asked if the alarm went off on 8/21/07 in the afternoon when R13 exited the facility. E11 said, "I do not know. My shift starts at 2:00pm. The first I heard about R13 being out of the building is when E10 called the facility to report that he was out."

Per record review, R13 has a care plan for elopement. It was last updated on 6/9/06. Under comments, the following was written:

9 . Staff to monitor tracking sheets.
10. Staff to be posted at elevators and exits.
11. Provide Supervision when resident is leaving the unit.
12. Resident is not to leave the unit with or without escort if behaviors are exhibited.

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F9999	Continued From page 18	F9999		

13. Check placement of electronic monitoring bracelet.

Added to the bottom of the care plan in a different handwriting under the title "NEEDS/PROBLEMS/CONCERNS" "Resident removes (name brand wandering monitor braclet)"

On 8/31/07, during a meeting with E2 (DON) and E3 (Corporate Nurse), E2 was asked for the "Monitor tracking sheets" for 8/21/07 on R13. E2 stated that there were none.

On 3 of 3 days of the survey, no one was observed strictly monitoring the elevators and exits on the 3rd floor. On 8/31/07, 3rd floor staff was asked who was responsible for monitoring the elevators and exit. They stated that they were all responsible.

2) On 8/30/07, Z4 (Son of R13) was interviewed in the first floor lobby concerning his father's care at the facility. Z4 complained about the facility putting his father in the same resident room 330 with R8. "R8 has hurt my father twice and they keep putting him in the room with him when he comes back from the hospital."

Per record review, R8 was admitted to the facility 6/11/07 to resident room 330. R8 was in bed #3 next to R13 in bed #2.

R8's admitting diagnosis was Alzheimer's Disease, Diabetes and Hypertension. The Initial Assessment, dated 6/22/07, reflected under Behavior Symptoms that R8 had physical abusive behavior 1 to 3 days of the 7 days; and resisted

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F9999	Continued From page 19	F9999		

care daily. Under the Mood State section on the Resident Assessment, dated 6/22/07, E12 writes: "Due to dx of dementia resident displays persistent anger with self or others, repetitive physical movements. Resident's mood persistence indicators present and not easily altered. Will proceed to care plan."

On 8/30/07, in the 3rd hallway outside of the large day room, E12 was interviewed about R8's behaviors and how often the residents residing in the 3rd floor Alzheimer's unit have their behaviors assessed and care plan approaches changed.

E12 stated that R8 had an aggressive behavior that is not easily altered. E12 further stated that he does assessments at admission and on a quarterly basis. Alzheimer's resident are not re-assessed when an incident is written.

In R8's Nurses Notes:
6/25/07, 11:30pm - R8 was involved in an altercation with roommate (R13). R8's Physician was called. The resident was given 2mg of Ativan and placed on 72 hour observation. The facility was asked for an Incident report because of the Physician being called. Facility staff stated that because it was not a Physical altercation, no Incident report was written.

R8 has a care plan dated 6/28/07, written for his persistent anger and physical abusive behavior with others. One of the approaches given was to monitor for any changes in R8's mood, behavior and/or cognition.

7/5/07, 12pm - R8 is combative with staff, kicking and hitting. R8 was, also verbally abusive to staff. "Medication that doctor ordered given and was

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F9999	Continued From page 20	F9999		

effective." No Incident report found.

7/14/07, 11:25p - 3pm-11pm reported to the 11pm to 7am staff that R8 struck another resident (R13). R8, who is in a low bed (approximately 4.75 inches from the floor) made of PVC plastic tubing had taken his bed apart. E13 (LPN) and E14 (LPN), both in written statements, said the bed was taken apart. E13, further states that R13's leg was bleeding from being "grazed by the bed frame." R13 was in a regular bed (approximately 18 from the floor). R8's Physician was called and the resident was given 2mg of Ativan. R13's Physician was called. R13 was put on 72 hour observation and his antibiotic ointment was tripled to the affected area twice a day until healed. No Incident Report was written per E13 written statement. Although R8, who had a prior altercation with R13 in resident room 330, continued to have escalating behavior, neither resident was removed from the room.

7/15/07, 10:20am - R8 pushed a television onto R13 resulting in a hematoma to his forehead. The resident was sent out to the hospital for a Cat Scan. When this incident occurred, R13 was on 72 hour observation from the night before. An Incident Report was written and both R8 and R13 remained in the same resident room next to each other. On 8/31/07, a very old television with a 16 inch screen was observed sitting on a night stand next to the closet in resident room 330. The television encompassed the entire top of the night stand. Because of the weight of the television, R8 would have had to have made a sincere effort using two hands to push this television over onto R13. Also, he would have had to be standing not sitting.

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F9999	Continued From page 21 R13 had two more hospitalizations - one on 8/21/07 (above Elopement incident) and another on 8/25/07. Each time R13 was returned to the same resident room and bed. R8 behaviors were not re-assessed after any of these incidents. (A)	F9999		