STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145752	A. BUILDING _____ B. WING _____	C 02/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR, THE	**535 SOUTH ELM ITASCA, IL 60143**

(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 490	Continued From page 12 interviews also reveal that clothing was taken off resident unnecessarily and was unable to be located. Staff inteviwed were not aware of facility policy on this and stated that from previous job, this was the norm if soiled or wet. Because clothing cannot be located, surveyor is unable to judge if it was soiled at time of locating R1.	F 490		
F9999	FINAL OBSERVATIONS 300.610a) 300.1210a) 300.1210b)6) 300.3240a) 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 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	F9999		

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F9999	Continued From page 13 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on Record Review and Interview the facility failed to have polices and procedures in place to prevent the neglect of one resident (R1) who was found on the ground in the courtyard at 5:15am on 02/05/09. The outside temperature was 1 degree F with a windchill factor -14 degrees F. The facility failed to supervise R1 who was one of eight residents being monitored by electronic monitoring devices, and failed to properly respond to a door alarm by turning off the alarm without checking resident security. R1 left the facility unnoticed (Door Alarm at Approx 2:15AM)	F9999		

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F9999	Continued From page 14 during the night of 02/05/09. R1 wandered outside the building into a locked courtyard. R1 was found in full arrest by paramedics in bed in the hallway after being moved from the outside approximately 30 min after she was found, and was declared dead at 6:03am. The facility did not have policies and procedures in place to ensure resident bed checks were being done. In addition, facility staff failed to follow the facility's policy and procedures on Building Exit/Entrance Monitoring by failing to properly respond to a door alarm. The facility also failed to have policies and procedures in place to check electronic monitoring devices to assure they were functioning properly. Findings include: R1's February 2009 Physician Order Sheet (POS) documents R1 as an 89 year old resident admitted to the facility on 10/16/06. She has diagnoses which include Depressive Disorder and Dementia with Psychosis. R1's medications include Zoloft, Aricept, and Risperdal. R1 has a Do Not Resuscitate order, and is to wear an electric monitor device at all times. A personal alarm is to be in place while in bed. R1's Minimum Data Set (MDS) dated 01/13/09 assesses R1 as having short term memory problems and having modified independence in making decisions for activities of daily living. R1's Nursing notes document that R1 has a history of wandering the hallways and wandering into other resident rooms. For example on 08/31/08 the notes document that R1 was up twice during the night. She was noted to be	F9999		

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F9999	Continued From page 15 confused to time and place. R1 was looking for "baby." Other examples include the notes dated 03/29/08 and 01/27/07. As of 02/09/09 there are no documented Nursing note for 02/05/09. R1's care plan does not address the use of the electronic monitoring device and personal alarms. On 02/09/09 at 10:30am, Z1, a physician, was interviewed in the facility Conference Room. He stated that R1 was a very confused resident whose safety awareness was poor. R1 probably would not have been able to get from the courtyard back into the facility. Z1 added that R1 needed supervision and benefited from the use of personal alarms and electronic monitoring device to monitor her whereabouts. On 02/09/09 at 01:50pm E6, a Certified Nursing Assistant (CNA), was interviewed by phone. She stated that she was assigned to care for R1 on 02/05/09. She stated she was resting in the resident lounge. "The last time I saw R1 prior to her being found outside was at 12 midnight during my rounds. I heard an alarm around 02:15am. We were wondering what it was. I went to the Nurses' Station and turned the black alarm button off. No one physically went to check the exit doors. At 05:00am on 02/05/09 I did not see R1 in her room. We found her out in the courtyard at 05:15am. She was wearing only a hospital gown and did not have any shoes on. She was cold, soft and Yellowish. R1 was not talking and did not appear to be breathing. R1 was transported to her room and oxygen applied. R1's gown was changed and 911 was called about 05:40am.	F9999		

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F9999	Continued From page 16 Facility staff failed to follow the facility's procedures on Building Exit/Entrance Door Monitoring when staff (E6) turned off a door alarm around 02:15am without following through with an exit or bed check. Specifically, Section 9(a) of those procedures requires that when a door or gate alarm sounds, "Nursing personnel will go to the door or gate which the signal came from. They will check to see whether the door was properly locked to prevent access to the building. The grounds in the immediate vicinity of the door will be checked to determine if anyone exited the building. If warranted, the door monitoring system will be reset. E5, a nurse, was interviewed by phone on 02/09/09 at 01:15pm. E5 stated she did not hear any alarms during the night. "When I first saw her outside her face was pale, she was cold, and her eyes were shiny and glazed. She was 'kinda' stiff. I told someone to change her clothes. I was taught that a person is to look respectable when going out to the Emergency Room. I do not know who changed the clothing. I told someone to call 911. I do not know who called. I answered the phone when 911 called back. I knew R1 was in serious trouble and would probably die soon. Nurses do not declare residents. I did not assess her vital signs. We brought her into the building and applied Oxygen." The surveyor attempted several times without success to contact E3 and E4, nurses who were also present in the facility on 02/05/09. The National Weather Service Report indicates the following at O'hare National Airport: at 02:52am -1 degree Farenheit (F) with no windchill factor.	F9999		

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F9999	Continued From page 17 at 03:51am-1 degree F with a windchill factor -14 degrees F. at 04:51am -1 degree F with a windchill factor -13 degrees F. E1 (Administrator) and E2 (Director of Nursing) were privately and individually interviewed on 02/09/09. They validated that the facility has no device of bedcheck sheets or that rounds were being made to monitor residents and their safety. There is no documentation or other proof that individual alarms are checked and working. Only their "presence" is checked off in the medical record. Door alarms are checked monthly to assure they are working. E1 was questioned why R1's room was the last room down the hall, about 55 feet from the nursing station and approximately 15 feet from the exit door leading to the courtyard. He stated that Admissions places residents in a room, and presently there is no system in place to keep residents with alarm devices closer to nursing supervision. On 02/10/09 at 02:30pm a phone conversation was conducted with Z2, a paramedic. Z2 stated that a 911 call was received approximately 05:43-05:45am. On route he was told that a resident was in full arrest. Upon arrival R1 was in the hallway in bed with Numerous blankets on. "All I was initially told was that this resident was a do not resuscitate and staff was preparing papers. R1 was extremely cold and had no pulse. The only vital sign we were able to obtain was the temperature. We took a tympanic temperature; it was low. When returned to the station we checked the manufacturer's book. It stated that the lowest temperature the thermometer was able to register was 68.8 degrees F. The temperature was below this. We	F9999		

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F9999	Continued From page 18 attached a three lead EKG and it was flat. We called a physician at a local hospital described R1's condition, and R1 was declared dead at 06:03am. Surveyors observed the location of R1's room on 02/09/02. It was the last room on the Northwest side right next to a door that is unalarmed. It goes to a staircase that leads to the second floor. At the end of the stairwell is an alarmed door that leads to the courtyard. This is the first of three exits to the court yard. The second exit is by the elevators; this is a keyed entrance. The third exit is in the dining room, which is near the middle of the building. (A)	F9999		