STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145872	A. BUILDING _____ B. WING _____	C 09/07/2011

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ALDEN LONG GROVE REHAB &HC CTR	**BOX 2308 RFD HICKS ROAD LONG GROVE, IL 60047**

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F 000	INITIAL COMMENTS	F 000		
F 323 SS=G	COMPLAINT 1172410/IL54007 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to supervise, monitor and determine the location of one (R2) of three residents assessed for high risk for elopement in the sample of five. This failure resulted in R2 eloping on 5/31/2011, after going to a doctor's appointment without an escort. R2 did not return to the facility after the appointment, but instead, walked to a grocery store, bought hard liquor and proceeded to go to a bar and consumed alcohol. R2 who has unsteady gait, had walked a mile or two, had to pass by major streets, cross multi lane traffic to reach the grocery store and bar. R2 was intoxicated and was taken to local hospital by the police. Findings include : R2 is a 38 year old with diagnoses of epilepsy, hepatitis, alcohol abuse, depression, bipolar	F 323		9/19/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 323	Continued From page 1 disorder, alcohol induced persisting dementia and CVA (cerebral vascular accident). R2 was originally admitted to the facility on 6/25/2010. Review of R2's "Community Survival Skills Assessment" showed the following: -- 4/6/2011 showed that "(R2) has poor short term memory due to alcohol abuse. At this time, (R2) needs supervision for any outside passes." -- 1/7/2011 showed that "(R2) has history of substance abuse , needs to be supervised for outside passes." -- 10/8/2010, "(R2) has short term memory loss due to substance abuse. (R2) often makes poor decision and needs supervision for outside passes." -- 7/7/2010, "(R2) makes poor decisions and judgement in the community related to substance abuse. (R2) needs supervision for passes at this time." Review of R2's "Elopement Risk Assessment " dated 4/6/2011 showed that R2 was assessed as " high risk due to attempts of elopement, setting off exit doors, verbalizes intent to leave." Review of R2's "Safety Assessment " dated 4/7/2011 showed that R2 had "attempted to elope from facility , setting off exit doors. Attempted several times to elope, difficult to redirect." Review of facility's "Elopement Details Report" dated 5/18/2011 at 3:30 P.M. , showed that "(R2) broke siding of his window, to get out of his room and to escape on ground level. (R2) is unable to care for himself and is verbally	F 323		

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F 323	Continued From page 2	F 323		

aggressive and potentially violent. (R2) refuses therapeutic interventions despite several attempts. (R2) made his way out to the parking lot but was redirected back to the facility and into his room. (R2) injured his right ankle related to escaping through window. (R2) says he will continue to escape until he succeeds."

Further review of this report indicated that R2 was sent to the local hospital on 5/18/2011 and was admitted due to a fractured ankle. R2 was later readmitted back to the facility on 5/20/2011 with an additional diagnosis of right distal fibula fracture and aggressive behavior.

Review of the nurse's notes dated 5/19/2011 showed that on 5/18/2011, "(R2) jumped from his window ledge , landing on an uneven surface that had caused the injury."

Review of current care plan dated 4/12/2011 showed that R2's pass privileges is at Level 1. It is also indicated that Level 1 needs supervision at all times. This care plan also showed that (R2) is unable to function independently without supervision or assistance related to alcohol induced dementia and signs and symptoms of short term memory loss. This care plan also showed that "(R2) looks persistently for a way to get out or get home, attempts to use the alarm, fire exit doors. "

The interventions for this current care plan were as follows:
-"check and assure physical comfort, staff will continue to monitor any cognitive changes in resident, continue with 15 minute check on resident to ensure safety, monitor behavior,

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F 323	Continued From page 3	F 323		

determine preferred setting, offer alternative ADL(activities of daily living) that maybe engaging".

Further review of care plan showed that there were no revised and specific interventions when R2 had eloped on 5/18/2011 resulting to an injury due to a fall from a window. There was no interventions to address how R2 is going to be monitored and supervised in an event R2 has outside medical appointments related to recent ankle fracture.

As a result of this failure, facility had sent out R2 to a doctor's appointment (orthopedic appointment) without escort/supervision on 5/31/2011 at 9:45 A.M..

Review of facility's investigation report dated 5/31/2011 showed that R2 did not return to the facility after a doctor's appointment, but instead, walked to a grocery store, bought a liter bottle of hard liquor and 6 pack of beer. R2 proceeded to go to a bar and consumed alcohol. Further review of incident report showed that R2 was intoxicated when found inside the bar by E3 (Director of Behavioral Unit), E4 (Counselor) and local police. R2 was taken to the nearby hospital by the police for detoxification.

E3(Director of Behavioral Unit) stated on 8/30/2011 at 11:15 A.M., that R2 has unsteady gait, had walked a mile or two, had to pass by major street, cross multi lane traffic to reach the grocery store and bar when R2 decided to eloped after a doctor's appointment on 5/31/2011. E3 also stated that R2 was endangering himself if he will consume alcohol as this might cost him

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F 323	Continued From page 4 his(R2's) life. E3 further stated that R2 should have been provided with an escort for supervision and to prevent R2 from elopement when R2 went out for a doctor's appointment. E3 continued to state that R2 was assessed as Level 1 for pass privileges which means it is the most restrictive pass and that R2 needs supervision at all times. E3 also stated that she and E4 (Counselor Behavioral Unit) and local police found R2 drinking alcohol inside a local bar. As E3 added, R2 was intoxicated and was brought to the local hospital by the police. E3 also stated that when R2 was found, R2 had a 1/2 empty liter bottle of Vodka that was found in his grocery bag. E3 also stated that R2 had a doctor's appointment at 10:00 A.M., left the doctor's clinic after the appointment, and was found after lunch approximately around 1:00 P.M. or 2:00 P.M. This indicated that R2's location was not known for approximately 2 to 3 hours. E4 (Counselor Behavioral Unit) was interviewed together with E3. E4 had validated what E3 had stated. E1 (administrator) stated 8/30/2011 at 1:30 P.M. that R2 was sent out to a doctor's office on 5/31/2011 without an escort from the facility. E1 has no explanation why the facility allowed R2 to leave facility while he was on the most restricted pass privilege (Level 1). E1 further stated that R2 was admitted to a behavioral unit in a local hospital after the elopement incident on	F 323		

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F 323	Continued From page 5 5/31/2011. E1 also stated that R2 had not returned back to the facility because R2 needed a more structured environment for close monitoring. Review of facility's protocol on elopement prevention, indicates that residents identified as being "at risk" for elopement should only leave the facility when accompanied by facility staff or responsible family member.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a 300.1210b) 300.3240a) 300.7020b)6) 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	F9999		

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F9999	Continued From page 6 b) The facility shall 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 resident care plan. 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. 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) Section 300.7020 Assessment and Care Planning b) The care plan shall be developed by an interdisciplinary team within 21 days after the resident's admission to the unit or center. The interdisciplinary team shall include, at least, the attending physician, a nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, the resident, the resident's representative, and the certified nursing assistant (CNA) who is primarily responsible for this resident's direct care, or an alternate, if needed, to provide input and gain insight into the care plan. Others may participate at the discretion of the resident. 6) The care plan shall be implemented and followed by staff who care for the resident. These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to supervise, monitor and determine the	F9999		

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location of one (R2) of three residents assessed for high risk for elopement in the sample of five.

This failure resulted in R2 eloping on 5/31/2011, after going to a doctor's appointment without an escort. R2 did not return to the facility after the appointment, but instead walked to a grocery store, bought hard liquor and proceeded to go to a bar and consume alcohol. R2 who has unsteady gait, had to walk a mile or two, pass by major streets and cross multi-lane traffic to reach the grocery store and bar. R2 was intoxicated and was taken to local hospital by the police.

Findings include :

R2 is a 38 year old with diagnoses of epilepsy, hepatitis, alcohol abuse, depression, bipolar disorder, alcohol induced persisting dementia and CVA (cerebral vascular accident). R2 was originally admitted to the facility on 6/25/2010.

Review of R2's "Community Survival Skills Assessment" showed the following:
-- 4/6/2011 showed that "(R2) has poor short term memory due to alcohol abuse. At this time, (R2) needs supervision for any outside passes."
-- 1/7/2011 showed that "(R2) has history of substance abuse , needs to be supervised for outside passes."
-- 10/8/2010, "(R2) has short term memory loss due to substance abuse. (R2) often makes poor decision and needs supervision for outside passes."
-- 7/7/2010, "(R2) makes poor decisions and judgement in the community related to substance abuse. (R2) needs supervision for passes at this time."

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Review of R2's "Elopement Risk Assessment," dated 4/6/2011, showed that R2 was assessed as " high risk due to attempts of elopement, setting off exit doors, verbalizes intent to leave."

Review of R2's "Safety Assessment,"dated 4/7/2011, showed that R2 had "attempted to elope from facility, setting off exit doors. Attempted several times to elope, difficult to redirect."

Review of facility's "Elopement Details Report," dated 5/18/2011 at 3:30 P.M., showed that "(R2) broke siding of his window, to get out of his room and to escape on ground level. (R2) is unable to care for himself and is verbally aggressive and potentially violent. (R2) refuses therapeutic interventions despite several attempts. (R2) made his way out to the parking lot but was redirected back to the facility and into his room. (R2) injured his right ankle related to escaping through window. (R2) says he will continue to escape until he succeeds." Further review of this report indicated that R2 was sent to the local hospital on 5/18/2011 and was admitted due to a fractured ankle. R2 was later readmitted back to the facility on 5/20/2011 with an additional diagnosis of right distal fibula fracture and aggressive behavior.

Review of the nurse's notes dated 5/19/2011 showed that on 5/18/2011, "(R2) jumped from his window ledge, landing on an uneven surface that had caused the injury."

Review of current care plan, dated 4/12/2011, showed that R2's pass privileges is at Level 1. It

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is also indicated that Level 1 needs supervision at all times. This care plan also showed that (R2) is unable to function independently without supervision or assistance related to alcohol induced dementia and signs and symptoms of short term memory loss. This care plan also showed that "(R2) looks persistently for a way to get out or get home, attempts to use the alarm, fire exit doors."

The interventions for this current care plan were as follows:
-"check and assure physical comfort, staff will continue to monitor any cognitive changes in resident, continue with 15 minute check on resident to ensure safety, monitor behavior, determine preferred setting, offer alternative ADL (activities of daily living) that maybe engaging."

Further review of care plan showed that there were no revised and specific interventions when R2 had eloped on 5/18/2011 resulting to an injury due to a fall from a window. There were no interventions to address how R2 is going to be monitored and supervised in an event R2 has outside medical appointments related to recent ankle fracture. As a result of this failure, facility sent out R2 to a doctor's appointment (orthopedic appointment) without escort/supervision on 5/31/2011 at 9:45 A.M..

Review of facility's investigation report, dated 5/31/2011, showed that R2 did not return to the facility after a doctor's appointment, but instead walked to a grocery store, bought a liter bottle of hard liquor and 6 pack of beer. R2 proceeded to go to a bar and consume alcohol. Further review of incident report showed that R2 was intoxicated

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when found inside the bar by E3 (Director of Behavioral Unit), E4 (Counselor) and local police. R2 was taken to the nearby hospital by the police for detoxification.

E3 (Director of Behavioral Unit) stated on 8/30/2011 at 11:15 A.M., that R2 has unsteady gait, had walked a mile or two, had to pass by major street and cross multi-lane traffic to reach the grocery store and bar when R2 decided to eloped after a doctor's appointment on 5/31/2011. E3 also stated that R2 was endangering himself if he consumes alcohol as this might cost him his (R2's) life.

E3 further stated that R2 should have been provided with an escort for supervision and to prevent R2 from elopement when R2 went out for a doctor's appointment. E3 continued to state that R2 was assessed as Level 1 for pass privileges which means it is the most restrictive pass and that R2 needs supervision at all times.

E3 also stated that she and E4 (Counselor Behavioral Unit) and local police found R2 drinking alcohol inside a local bar. As E3 added, R2 was intoxicated and was brought to the local hospital by the police. E3 also stated that when R2 was found, R2 had a half empty liter bottle of Vodka that was found in his grocery bag. E3 also stated that R2 had a doctor's appointment at 10:00 A.M., left the doctor's clinic after the appointment, and was found after lunch approximately around 1:00 P.M. or 2:00 P.M. This indicated that R2's location was not known for approximately 2 to 3 hours.

E4 (Counselor Behavioral Unit) was interviewed

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F9999	Continued From page 11 together with E3. E4 validated what E3 stated. E1 (administrator) stated on 8/30/2011 at 1:30 P.M. that R2 was sent out to a doctor's office on 5/31/2011 without an escort from the facility. E1 has no explanation why the facility allowed R2 to leave facility while he was on the most restricted pass privilege (Level 1). E1 further stated that R2 was admitted to a behavioral unit in a local hospital after the elopement incident on 5/31/2011. E1 also stated that R2 had not returned back to the facility because R2 needed a more structured environment for close monitoring. Review of facility's protocol on elopement prevention indicates that residents identified as being "at risk" for elopement should only leave the facility when accompanied by facility staff or responsible family member. (B)	F9999		