STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS

Ambassador Nursing Center **Facility Name**	0004077 **I.D. Number**

4900 North Bernard Street Chicago IL 60625 **Address**	
	02/20/04 **Date of Survey**
Complaint Investigation **Type of Survey**	

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.1210 a) 300.1210 b) 6)	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. *Personal Care, as defined in section 300.330 is assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual (Section 1-120 of the Act).* 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. Based on record review, incident report, police report, hospital report, staff & physician interviews and observations, the facility failed to supervise 1of 13 residents assessed as high risk of elopement and prevent the resident from leaving the facility unsupervised. (R3) had diagnoses of dementia, psychosis and wandering seeking behavior, with a history of attempting to leave the facility. On 02/01/04, R3 left the facility. R3 has an electronic monitoring device on the right wrist and left ankle but was able to leave the building unnoticed. Findings include: Review of R3's medical record revealed that facility admitted R3, from another facility, on 5/6/03, with diagnoses of psychosis and high risk for elopement. R3 has eloped from several facilities in the past according to available records. R3 is documented as "high risk, and is a very smart lady and may attempt to leave with visitors or walk out." Review of the social service admission notes, signed by E11 on 5/6/03, reflects that R3 only speaks Spanish. R3 's medical record also denotes that R3 tried to
300.1210 a)	elope on 6/21/03, 11/16/03, 11/28/03, 11/29/03, 1/10/04 and 1/11/04. Review of R3's physician order,

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300.1210 b) 6) (Cont.)	dated on 5/6/03, reveals an electronic monitoring device was placed on R3's right wrist and left ankle. Surveyor reviewed the facility's incident report dated 2/2/04. During the 11:15PM rounds, staff noted that R3 was not in her room. The staff initiated a room-to-room, floor-to-floor search however, R3 was not found in the facility. Progress notes, dated 2/2/04 at 12:05AM and signed by E6 (nurse), revealed that Z1, a police officer from the hospital, phoned the facility and asked if they were missing a resident. The officer stated that the resident was in the hospital emergency room & had been found wandering the street. Review of the police report, dated 2/1/04 at 11PM, revealed that R3 was found wandering outside of the hospital emergency room, demented and confused. R3 was only wearing an orange tee shirt, grey pants, and sandals with no socks. According to the report R3's feet "appeared frostbitten." Review of R3's emergency room documentation dated, 2/2/04 at 12:28AM, reveals that R3 received treatment for frostbite of the right & left great toes. R3's feet were "swollen with redness." R3's vital signs were blood pressure 125/74, heart rate 99, respiratory rate 22 and temperature 96.9. R3 was described as alert and confused, only able to speak Spanish and initially unable to give any information. Surveyor reviewed the facility's incident/accident report, dated 2/3/04, and provided by the facility on 2/17/04. The report included written statements by E3, E6, E16, E17, & E18. These employees all stated that they did not hear the door alarms ring on 2/1/04 between 8PM and 9PM. Surveyor interviewed E3, in the conference room on 2/11/04 at approximately 2:20PM. E3 stated that in December 2003, when E3 checked R3 for her electronic monitoring device, the device was missing. R3 told E3 she cut the device off her ankle. E 3 stated she immediately reapplied a new electronic device to R3. E3 and other staff were then aware that R3 was capable of removing the device. Surveyor interviewed E13 on 2/11/04. E13 stated that visitor hours are over at 8PM although some visitors may leave later and that might be how the resident left. When the receptionist that monitors the front door leaves, the alarm is on an automatic timer that goes on at 8PM. E13 stated the electronic monitor device signal at the door is always on to ring when triggered by the device that a resident may wear. According to surveyor interview of E11, on 2/11/04 at approximately 11AM in the conference room, E11 stated that the facility applied the electronic monitoring device to R3's wrist and ankle the day of R3's admission to the facility. E11 further stated that she and E7 check electronic monitoring devices to make sure that they are working. E11 stated one time R3 was not wearing the electronic device; R3 told E11 that she cut the electronic device with a pair of scissors. Surveyor interviewed E4, on 2/12/04 approximately 2:45PM in the basement conference room. E4 stated that she administered E3 a sleeping pill between 8:15 and 9PM on 2/1/04. R3 was in her room at this time. This was the last time she saw R3 on the unit. When surveyor asked E4 if there were any visitors on the floor at this time, E4 replied that there were no visitors on the unit.

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300.1210 a) 300.1210 b) 6) (Cont.)	In a telephone interview with E6, on 2/17/04 approximately 1:40PM, E6 stated that she made rounds at 11:15PM and noticed that R3's bed was "ruffled". When E6 asked the CNA if she had seen R3, the CNA stated that she had not seen her. E6 further stated that this is when the staff started checking the facility. R3 was not in the facility at the end of the search. Surveyor asked E6 if there were any visitors on the floor at this time, and E6 replied no visitors were on the floor. E6 stated at 12:05AM on 2/2/04 she received a telephone call from Z3 who stated that he was calling from the hospital and wanted to know if we were missing a resident whose name was R3. Z3 stated that he received a call at 11:10PM that R3 had walked into the hospital ER with sandals and no socks. Facility had not called family, MD, or police to notify them of R3's absence at the time they received the call from Z3. On 2/11/04 at approximately 11:30AM surveyor interviewed R3, with E11 serving as an interpreter, in R3's room. R3 stated that she walked out of the facility through the front door. As they continued, R3 could not answer questions appropriately. Surveyor observed E5 change R3's bandages on her feet. The frostbite area was clean and dry with peeling skin. R3 did not express any discomfort during the dressing change. On 2/17/04 surveyor observed E12 during the dressing change. R3 had an electronic monitoring device on her right wrist that was loose. There was a monitor on her left ankle. E14 (serving as an interpreter) asked R3 if she could remove the electronic monitoring device from her wrist. R3 was able to remove the monitoring device in the presence of the surveyor, Z2, Z3, & E12. On 2/11/04 at approximately 1PM surveyor toured the facility with E7, and all of the alarm exits were checked. The alarms were functioning. On 2/17/04, surveyor and E2 walked with R3 through the alarm exits. R3's electronic monitor device was working at this time as the alarm sounded. Surveyor measured the distance from the facility to the hospital as 4.5 miles. Review of the hospital documentation dated 2/1/04 at 12 midnight, reflects that R3 stated she walked from the facility to the hospital. Temperatures obtained on 2/17/04 from the National Weather Service at Midway Airport for 2/1/04 at 8PM to 12AM; the outside temperatures ranged from 10^{o} to 11^{o} Fahrenheit. "A"