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 08/26/2005

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 698	Continued From page 6 evaluated quarterly in QA comittee by DON and Administrator who will be responsible for implementing.	F 698		
F9999	FINAL OBSERVATIONS STATE VIOLATIONS ASSOCIATED WITH THE INCIDENT OF 07/29/2005 300.1210a) 300.1210b)6) 300.3100d)2) 300.7050b) 300.7060a) 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 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) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour,	F9999		

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F9999	Continued From page 7 seven day a week basis: 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. 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. The unit shall have assigned, consistent staff. There shall be enough staff to meet the scheduled and unscheduled needs of each resident, as defined in the care plan, taking into account the purpose of the setting, the severity of dementia, and the resident's physical abilities, behavior patterns, and social and medical needs. The environment (cultural, social, and physical) shall support the functioning of cognitively impaired residents. It shall accommodate behaviors, maximize functional abilities, promote safety, and encourage residents' independence by compensating for losses resulting from the disease process in accordance with each resident's care plan. These regulations were not met as evidenced by: Based on record reviews and staff interviews the facility failed to provide adequate supervision to prevent elopement and physical harm for one resident (R3). R3, who was diagnosed with	F9999		

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Alzheimer ' s disease, had made several attempts to leave the building earlier. Resident was noted missing by staff 7/29/05 in early AM and was found by a staff traveling to work 2 miles away from the facility. The facility had left their alarm doors open to allow for staff and lab to enter the building. Staff had heard no alarm that morning.

Findings include:
Per record review, R3 is an 86-year old male with diagnoses that include Dementia, Glaucoma, Alzheimer ' s disease, Left eye Cataract, Asthma, DJD (Degenerative Joint Disease), Osteoporosis, HTN (Hypertension) and CAD (Coronary Artery Disease).

Nurses notes dated 07/28/05 at 10:30PM reflect "Resident trying to get on elevator to leave, staff consistently redirecting him. Endorsed to 11-7 to monitor for elopement precautions." Facility staff were aware of his elopement risk prior to R3 being found missing.

E4 (Rehab Aide) was interviewed on 08/23/05 at 1:05PM, E4 stated that "When I was on my way to work on 07/29/05 at around 5:35AM, just before I got to 95th street, turning right to Halsted Street at stop light, I saw a man crossing the light headed south of 95th street, he looked like R3. I went ahead and headed for work, I went to a fast food restaurant at 111th Street and Halsted Street, and then came to work. When I got to work a staff nurse told me that R3 was missing. I told the nurse that I saw R3 at 95th Street and Halsted Street. I went to my car, went back and saw R3 at 99th Street and Halsted Street going south. I spoke with R3 and told him that I'm there

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if he wants a ride. R3 stated, 'yes baby I'm tired.' I brought back R3 to facility. R3 was wearing dark shaded glasses, long sleeves shirt, regular pants and a bible on his hand. I observed a little knot on R3's forehead with little blood and upper lip with little blood too." E4 further stated that at the time R3 was picked up, the traffic was light, not heavy.

E5 (Receptionist working 2PM-9PM) was interviewed on 08/23/05 at 2:20PM. E 5 stated "Before I leave I make sure that all doors are secured except the 2 front doors because we don't have policy of alarming the 2 front doors. I let the first floor nurse know that I'm leaving. No specified staff sits in the reception area when I leave to watch either the camera or door. I don't have a break; I call a CNA (Certified Nursing Assistant) when I go to bathroom. 2 front doors are left without the alarm. Now, before I leave, I alarm all doors including the 2 front doors."

E10, CNA ,was interviewed on 08/23/05 at 3:10 PM and stated "R3 was saying he wants to go home and trying to leave, trying to get into the elevator. I told R3 that he has to stay up here with us and R3 said 'No, I don't live here.' I showed R3 his room but R3 still kept wanting to leave for the whole shift that day (07/28/05). R3 keeps going to the elevator trying to leave anyway he can. R3 refuses to go to bed. R3 was still up sitting near the nursing station and other CNAs were aware of R3's trying to leave. We monitored R3 and told 11-7AM shift."

E6 (11-7 Nurse) was interviewed on 08/24/05 at 11AM via telephone and stated "On morning of 07/29/05 between 2:30AM to 4AM a man rung

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the bell. I was at the first floor nursing station. I went to check and I opened the door for the man by just pressing the buzzer behind the front desk to let him in. He dropped a lot of envelopes (Lab orders) and he left right away. Later a lady picked up all the envelopes and also left right away. About 30 minutes before 5AM a lady came in and went upstairs to draw the blood. I was not the one who let her in, the Supervisor let her in, then I saw the lady leave the building by herself. The Supervisor was not with her. Door automatically locks. I was passing medications between 5-5:30AM and discovered that a resident was missing, so we stopped what we were doing and looked around." Surveyor asked E6 if she views the camera that is on the exit doors and E6 replied
"No the supervisor does."

E7 (Nursing Supervisor) was interviewed on 08/23/05 at 3:55PM. E7 stated "on July 28, 2005 I worked 11-7AM. That night I made rounds as usual. I made rounds at 4:30AM. That's when they told me that R3 was missing. E7 said that he was last seen between 3:30AM to 4AM.
E8 (CNA) said she went to look for him after 4AM . We looked everywhere inside for 30 to 45 minutes then went outside the neighborhood to look for him. 3-4 staff went in different cars for a good hour. That's when an employee who was coming into work informed us that she had seen R3 on the street on her way to work. No we did not call police"

E8 (11-7 CNA) during interview on 08/24/05 12 PM, stated that she had received report from the 3-11 nurse about R3 having behavior change, acting out, pacing and trying to leave the unit. E8

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stated that on her shift, R3 was pacing the unit back and forth and wearing blue jeans and long sleeve shirt with buttons and wearing dark sunglasses. R3 had been pressing the elevator door and was attempting to leave. R3 crossed the double doors to the other unit (3 North) and attempted to leave 3 times that night and had to be escorted back. R3 stated that people were waiting for him outside.

E8 stated that she had three other residents who were also acting out behavior that night. There were two other staff on the unit but they were busy with a resident having an asthma attack. E 8 indicated that she was taking care of 27 residents that night. E8 indicated that she last saw R3 going back to his room (#328) at 3AM holding a snack. E8 became busy with the residents that were up (R6, R7, and R8) and only started making rounds at 4AM starting at room 315
(farthest from R3's room) to 328, R3's room. That's when she (E8) noted that R3 was not in his room and the staff started looking for R3. E8 indicated that they spent time looking inside the unit then reported the resident missing to the supervisor. E8 further stated that she and other staff did not hear any alarm that indicated R3 had left the building and the alarms were off. E8 stated that she and other staff went out to look for R3 for around one hour.

Review of statements of E6, E9 (CNA) and interview of E6 and E8, all indicated that they did not hear any alarm throughout the 11-7 shift that would have alerted them that the resident wandered out of building after 3AM.

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F9999	Continued From page 12 Facility incident report sent to the Illinois Department of Public Health was provided by E1. The facility incident report investigation showed inaccuracy in reporting as it reported R3 was identified missing at 5:15AM. Interviews show staff had identified him missing after 4AM after last being seen at 3AM. E4 found the resident 2 miles from facility on a busy intersection of 95th Street and Halsted Street crossing the streets going southbound at dawn wearing dark sunglasses at 5:35AM. R3 just had an eye surgery and was required to use the dark sunglasses which further reduced his vision and posed a threat. E4, after possibly recognizing R3 as a resident did not immediately confirm his identity and return him to facility but stopped for fast food and then went into work. During this elopement, facility identified that R3 sustained red bruise to his upper forehead and lower lip per incident report. However, E4 who escorted R3 back to the facility added there was also a little knot on his right forehead that was bleeding and upper lip also bleeding. The temperature during the time he was out was 59 degrees Fahrenheit according to the Newspaper weather report for that day.	F9999		