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	145798	A. BUILDING _____ B. WING _____	C 08/09/2005

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F 406	Continued From page 18 may be taken including up to involuntary discharge. 11. The Administrator and Director of nurses will monitor that the above actions are ongoing and effective via Quality Assurance monitoring program. Weekly 12. Criminal Background checks on all current residents have begun and also being completed on all new admissions. Those found to have histories in violation of the newly implemented admission policy may be issued an involuntary discharge and alternate placement will be sought.	F 406		
F9999	FINAL OBSERVATIONS Licensure Violations 300.3240a) 300.1210a) 300.1210b)4 300.1420a) 300.1420b) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) 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 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	F9999		

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F9999	Continued From page 19 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: 4) Personal care shall be provided on a 24-hour, seven day a week basis. Section 300.1420 Specialized Rehabilitation Services If physical therapy, occupational therapy, speech therapy or any other specialized rehabilitative service is offered, it shall be provided by, or supervised by, a qualified professional in that specialty and upon the written order of the physician. (B) a) In addition to the provision of direct services, any such qualified professional personnel shall be used as consultants to the total restorative program and shall assist with resident evaluation, resident care planning, and in-service education. b) Appropriate records shall be maintained by these personnel. Direct service to individual residents shall be documented on the individual clinical record as set forth in Section 300.1810(c). A summary of program consultation and recommendations as set forth in Section 300. 1810(h) shall be documented. Based on staff and resident interviews and records reviewed the facility failed to: 1. Provide supervision and monitoring for the entire C -D wing of the facility which currently houses over 90 residents. There was no staff present on the unit for a period of 5-10 minutes on 7/02/05 between 11:30PM and 11:40PM.	F9999		

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F9999	Continued From page 20 During this time a resident (R2),on the C-wing was physically assaulted by R4 and R5 while asleep in bed causing severe facial injuries and hospitalization. 2. Provide supervision and monitor residents (R4 and R5), with documented history of recent, repetitive physically aggressive behaviors. This resulted in one resident (R2), being physically assaulted while in bed asleep by R4 and R5. 3. Protect other residents from being physically abused by residents with multiple incidents of physically aggressive behaviors (R4 and R5 and R6). 4. Update care plans for residents (R4 and R5 and R6), to indicate new goals and approaches for the continued aggressive behaviors which posed a threat to all residents on the unit. This failure resulted in R2 being physically assaulted while asleep in bed on 7/2/05 between 11:30PM and 11:40PM. R2 sustained severe facial injuries that required 26 sutures to the face and hospitalization.Other residents on the unit were also at risk due to the aggressive behaviors documented for R4, R5, R6. Findings include: Per record review, R2 was admitted to the facility on 11-01-04 with a diagnosis to include Schizoaffective disorder with Psychosis. R2 was alert but forgetful and has documented incidents of being sexually inappropriate toward nursing staff, increased anxiety and agitation, withdrawn from group therapy and social activities and recent verbal and physical altercations with	F9999		

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F9999	Continued From page 21 peers,i.e. 6/25/05 and 7/02/05. R2 ambulates independently. Per review of facility incident report and investigation of R2's 7/02/05 injury, R2's medical record and the Police report(#05-12081) and staff interviews of E21, E2 (Director of Nurses), E 4, E6, E11, E12 and E18(nurses)and E16 and E 17(nurse aides), on 7/02/05. R2 was physically assaulted while asleep in bed at approximately 11:30PM. On 7/2/05 during the 7AM-3PM shift, R2 was acting sexually inappropriate toward E4 and R4 and R2 had a verbal altercation. E11 said that R2 continued to have increased agitation on 7AM-3 PM shift and required a psychotropic injection to be administered to calm R2 down. R2 went to bed shortly after receiving this injection and only got up to eat and wash up and then went back to bed. Documentation reviewed and interview of E21, E 18 and R7 state that on 7/2/05 sometime between 11:30Pm and 11:40PM, while R2 was asleep in his bed, R2 was physically assaulted in the face, causing a laceration to the top of his lip, on his forehead and right cheek. R2 also sustained a swollen right eye. R2 was observed in bed moaning with blood all over his face by R7 . R2 walked out to the C-D nurses station, where he was observed standing by E18. R2 required 26 sutures to close the facial lacerations and hospitalization. E18 and E4 had both punched out at approximately 11:30PM on 7/2/05. E4 said that she saw E18 outside after punching out at	F9999		

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approximately 11:30PM, waiting for a ride to pick her up. E18 told surveyors that when her ride did not show, she went back in the facility and walked back to the C-D nurses station to call her ride on the phone, at which time she observed R 2 standing at the nurses station with blood all over his face. E16 and E18 stated that E16 had left the C-D unit at approximately 11:30PM to go to the laundry room, prior to E18 going out front to wait for her ride. E16 said that she was off the unit for approximately 10 minutes and upon return, E16 saw E18 treating R2's bloody face at the C-D nurses station.

Interviews of E16 and E18 validated that E16, E 18 and E4 were the only staff working on the C-D wing on the 3PM-11:30PM shift of 7/02/05. E16 stated that the 11PM- 7:AM nurse aide did not arrive on the C-D wing until after 12:15AM on 7/ 03/05. E18 and E12 both stated that E10 (the assigned 11PM-7AM nurse), did not arrive until after R2 was observed bleeding at the nurses station by E18. E15, E17 and E12 all stated that they did not work on the C-D wing on 7/02/05.

On 7/27/05 R3 told E21 and surveyor that he knew that R4 and R5 were the perpetrators that assaulted R2 on 7/02/05, causing his facial injuries. R3 said that he was afraid to tell on R4 and R5 before this, but since R4, R5 and R6 are now discharged from the facility he felt safe enough to tell the truth.

R4, R5 and R6's medical record documents multiple physical abuses toward residents between 3/05 and 7/27/05.

1) R4 has diagnosis to include Paranoid

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F9999	Continued From page 23 Schizophrenia, mood swings and depression. R4's medcial record documents on: 6/12/05 he became increasingly agitated and attempting to act out physically toward others . R4 had a physical altercation with a peer. 7/7/05 physically abused a peer. 7/21/05 yelling and verbally abusive toward his room mate. 7/26/05 when interviewed by surveyor and E 21 about his knowledge of the 7/2/05 assault incident toward R2, R4 started screaming, hollering and yelling and had increased level of agitation and attempting to act out physically toward staff and peers. R4 sent out to the hospital. R4's 5/25/05 quarterly assessment states that R4 may try to bully other residents. Resident is not cooperative with treatment. The resident's response to treatment can be described as able but unwilling. R4 was not on any behavior contract for his aggressive and bullying behaviors . 2) R5 has diagnosis to include Schizoaffective disorder, Depression and history of drug use. R5's medical record revealed: 4/26/05 punched a peer in the face and knocked him down on the floor. 5/11/05 increased level of agitation with auditory hallucinations, telling him to push peers and staff. 5/18/05 increased agitation and attempting to act out physically toward peers. 5/19/05 physical altercation with peer and violated the drug/ alcohol behavior contract. 5/27/05 yelling and screaming and hollering, increased agitation and anxiety. Verbal and	F9999		

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physically aggressive toward peers.

7/10/05 went into a peers room after visiting hours against the redirection of the staff, screaming and hollering and physically aggressive toward staff.

7/26/05 during interview by surveyor and E 21 about the 7/02/05 incident involving R2's facial injuries R5 started screaming, hollering and yelling. Increased agitation and anxiety, attempting to act out physically toward staff and peers. R5 was "sent out to a psychiatric hospital on 7/26/05 for stabilization of current symptoms and to prevent harm to self and others."

R5's 7/13/05 quarterly assessment note states that R5 has not been hospitalized in the past quarter. R5 has potential for substance abuse relapse, may use alcohol and illegal drugs. R5 has not attended any of facility's relapse prevention programs.

R5 had a behavior contract dated 5/19/05 and one dated 8/6/04 for drug and alcohol use and the contract notes that R5 must attend facility's relapse prevention program. R5 was given another behavior contract for drug and alcohol use on 7/26/05. R5 was not on any type of behavior contract for physical aggression toward others. Care plan dated 4/27/05 states that R5 may become verbally and/or physically aggressive towards others. Care plan notes that R5 will instigate or provoke verbal altercations and physical altercations. R5 will bully peers, may attempt to swing or kick at others. R5 may threaten others in an attempt to get his needs met. R5 has poor judgement and low frustration level.

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3) R6 is alert and oriented X3 and has no psychiatric diagnosis. R6's 5/19/05 assessment for aggression stated that R6 has attempted to become physical with peer. R6 verbalized that the peers are violating his personal space. R6 has documented episodes of alcohol / illegal drug use while a resident at the facility. R6's 7/26/05 urine drug screening was positive for Cocaine metabolites, Opiates and Cannabinoids. R6 was placed on a drug/ alcohol use behavior contract on 8/5/04, 12/13/04 and 7/26/05. This contract stated that R6 must attend facility's relapse prevention program twice a week. E23 (Clinical Director of psycho social programs and behavior contracts) stated that R6 has attended 21 of the possible 40 relapse programs and 7 of possible 20 psycho social groups between 3/05 and 7/05. R6's 5/19/05 care plan states that R6 has increased agitation and anxiety, may engage in verbal / physical altercations with peers. The intervention was to teach R6 how to handle the anger. R6 was given a Behavior contact on 01/28 /05 for having physical altercation with peers. The contract says that R6 must attend psycho therapeutic groups twice a week.
Medical records revealed that R6 on:
4/20/05 hit a peer in the head with an ash tray
5/18/05 involved in a physical altercation with a peer. R6 was kicking and punching the victim while another resident held the victim.
6/12/05 increased agitation and had a physical altercation with a peer.

On 7/27/05 R6 was approached by E21 about the positive drug test and his pass privileges were suspended as per the drug / alcohol contract. R6 signed the contract again on 7/26/05 but became

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F9999	Continued From page 26 angry and signed himself against medical advise and discharged himself from facility.	F9999		

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F 324	Continued From page 9 C. Staff has been inserviced regarding the new door alarm sounds and addition of indicator lights. Staff has also been inserviced regarding the facility's wandering /elopement policy. 4. The Administer and DON will monitor that these actions are ongoing and effective via the following Quality monitoring programs: A. A weekly review of all incidents of all incidents and accidents will be held. Incidents involving incidents involving resident elopements will be carefully investigated to determine causal/ contributing factors. Care plans will be updated as warranted. B. Mock door alarm drills have been held to test and evaluate staff response to possible elopement or wandering resident risk. Noted problems will be addressed immediately and identified patterns or trends will be brought to the Quality Improvement Committee for further corrective action(s). C. The facility has reviewed and updated its Wandering and Missing Resident Policy and Procedure (a copy of this policy is attached to this abatement report). 5. All of the above listed items were completed by August 4,2005.	F 324		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a)	F9999		

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F9999	Continued From page 10 300.1210b)4 300.1210b)6 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 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: 4) Personal care shall be provided on a 24-hour, seven day a week basis. This shall include, but not be limited to, the following: 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. Based on review of facility incident report, elopement policy, clinical record, and staff interviews, the facility failed to prevent one resident (R3) who had a clinical diagnosis of being legally blind, had a previous history of wandering, had an assessment to have pass privileges with relatives and community access with staff supervision , from leaveing the facility through an alarmed door, and to be missing for approximately 6 to 7 hours. R3 was found at approximately 2:00 AM, August 2, 2005 in a tennis court, in a backyard of a house which was	F9999		

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behind the facility. R3 had been noted missing at approximately 7PM on August 1, 2005.

Review of R3's clinical record indicates that R3 is a 67 yr old male, who was admitted to the facility on 8/17/99. His diagnoses include Hypertension, Hard of Hearing, Blind Both Eyes, Syncope, Vertigo, Dementia w/ Aggression, Anemia.

R3's most recent Minimum Data Set of 08/11/05 denotes a Cognitive Level of 2, moderately impaired, decisions poor, cues supervision required. R3's Vision code is at 4, severely impaired--no vision or sees only light, colors, or shapes; eyes do not appear to follow objects.

Most current care plan of 08/09/05 as well a last annual of 8/12/04 and other care plans provided by facility, 5/12/04, and 11/09/04, specify blindness as a problem with increased risk for injuries and approaches which include to monitor and remove environmental hazards. Past care plans of 5/12/04, 8/12/04, 11/09/04 indicates that R3 had a problem as an identified wanderer with approaches to monitor and to know R3's whereabouts.

Social service notes of 7/25/05 denote under heading Resident Passes that resident (R3) may go out on pass with relatives. Must pick-up and drop off at the facility. Also resident may go into community with supervision of facility staff.

Computerized summary nurses notes dated 8/02/05, 04:35 AM, by Z1, (A-wing , nurse and former employee), document that on 8/01/05, R3 had been observed walking slowly down A-wing corridor, and that Z1 had been summoned by R1,

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F9999	Continued From page 12 R3's roommate, to redirect R3 back to his room, AA-1, at 6:15 PM.and that he was placed sitting on his bed and instructed to stay in his room at that time. These nurse notes document that at 6: 35 PM, counselor, (E8), informed her to call Code W, (facility's code to alert staff of resident's elopement), it was called and entire staff began search at 6:37 PM inside and outside facility. Attempted phone contact with Z1 to verify her recollection of these events was without success. Review of facility incident report form of 8/01/05 documents that resident was noted missing at approximately 7 PM and staff called a code for missing person, room to room search was completed as well as a 5 mile radius search in all directions, local police were called, and the family was in the facility. Resident was found, body check done revealed no injuries, sent out to the hospital for evaluation per family request and returned to the facility. The Attending physician was made aware. Further review of this incident report and E2's investigation with interviews with staff and residents and follow-up indicated that the resident was last seen between 6:30 PM and 7 PM . All doors were checked and secure. Some staff and a couple of residfents reported hearing alarm. The nurse on the unit was notified by the counselor that the resident was missing. The nurse did not know herself that the resident was missing or who had turned off the alarm. Interview with Director of Nurses (E2) 8/15/05,4: 15 PM, she stated that "all the facility doors are alarmed so as to alert staff if someone should try	F9999		

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F9999	Continued From page 13 to leave unescorted. The front door is also alarmed and there is always someone to monitor it. Any staff of visitors have to be buzzed in or out. The other doors of the specific wings have 15 second delay which means when the door is touched it takes 15 seconds before it will open. The alarm will continue until turned off with a special key. E2 believed that R3 had left through the A-Wing door". Surveyor checked each wing door alarms, including the patio door, on 8/16/05, at approximately 11:30 AM, with E2. All of these doors had special key locks, the door was pushed and the alarm sounded and within 15 seconds the door could be opened. E2 would dismantle the alarm with the key. The front door had a key pad with a code, that had to be released before exiting. The receptionist would monitor while on duty and buzz a staff or visitor in or out of the front lobby door. Assigned CNAs (Certified Nursing Assistants) would monitor the lobby door after the receptionist would leave for the day. E2 further stated that "the nurses follow normal procedures to assure residents are accounted for. Rounds would be made at least every 2 hours by nurses and CNAs". During interview of 8/16/05, E2 stated that she " interviewed the staff on duty the evening that R3 had been found missing and found that staff on duty were at their assigned posts except Z1. She was to be monitoring wings A and B while the CNAs were in the Dining room and Sun room. Z 1 was not on her assigned monitoring area, she was nowhere to be found. Z1 is no longer working in the facility".	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145798	A. BUILDING _____ B. WING _____	C 08/22/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE HEALTHCARE CENTER	**1635 EAST 154TH STREET DOLTON, IL 60419**

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Surveyor obtained staffing for night of R3's elopement and conducted interviews with available staff on duty the evening of 8/01/05.

8/16/05, 3:40 PM, interview with CNA (E6) working on C and D wing on 8/01/05 evening shift, stated had "heard the alarm go off, thought it was around 7or 8 PM. Was not sure where the alarm was coming from. Staff were checking to see which door alarm was on. A lot of staff were down by the A-wing door. The counselor(E8) had gone out to the immediate area and didn't see any body. We started a room check and head count and found that R3 was missing. Not sure who shut the alarm off. Searched the building at least 5 times. Did not think R3 could have gotten outside by himself. He is blind and usually makes his way along the wall in the facility".

8/16/0, 4PM, interview with CNA,(E7) B-Wing, stated " was in a residents room from around 7: 10 PM, and didn't here an alarm until I was monitoring the lobby at my assigned time at 7:30 PM". I did not know where it was coming from, and couldn't leave the lobby. I heard the Code W called".

8/16/05 interview with E8, stated was "made aware around 7:40 PM by the D- wing nurse(E9) that R3 was missing" . E8 stated "had not heard an alarm go off because I was in my office with the door closed eating lunch with my co-worker (E15)." E8 stated that " E9 told him that she spoke to the family of R3 when she had gone to the A- wing to get some supplies and the family had told her that R3 was not in his room." E8 continued that after this information he "went to

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F9999	Continued From page 15 the A-wing initially to look for R3 and ask the nurses on the A-B unit if they had seen R3." E8 stated that "the nurses, Z1, E10 and E13 were at the A-B wings nurses station The nurses did not appear worried, and thought R3 had wandered down the hall." The nurses had not mentioned to him that a door alarm had gone off. After this he "paged for CNA's to the nurses station to assist in doing a head count." E8 stated they also "did ground searches." "Two CNAs and the other counselor (E14) responded." E8 then "notified the Clinical director (E4). Prior to E4's arrival E8 stated "I checked the A-wing door and attempted to re-enact what could have happened and pushed against the door and the alarm went off." E8 stated "was myself, Z1 and some other staff, by the A-wing door." E8 continued "that during the course of the evening the patio door had gone off, a female resident had set it off several times. After opening the A-Wing door, another ground search was done, we checked the neighborhood, went to the retirement building on the corner. Continued to search, it was getting dark when the Clinical director, (E4) arrived, around 8:25 PM." E8 stated," the police showed up, I thought the family had contacted them." E 8 stated "I left at around 12:30 AM and R3 had not been found yet." . 8/17/05, 3:00 PM, interview with D-wing nurse E9 stated "thought I heard an alarm at around 5:45 PM., I came out of the dining room to investigate. After I checked the C-wing door, I walked toward the A-B wing and as I walking down that way I ran into a family member of R3. This family member said that R3was not in his room and asked the nurse at the station, Z1, where R3 was, and she said R3 was walking around. I said	F9999		

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F9999	Continued From page 16	F9999		

R3 doesn't walk around by himself. So after checking R3's room I asked the Nurse Z1 where R3 was, and Z1 said I don't know he was walking around." E9 stated "there were Nurses at the A-B nurses station and the alarm at the A- wing door was going. Most of the CNAs were in the Dining Room, helping residents so I went down to the alarmed A-wing door, but didn't have my key. I looked through the door and didn't see anybody and so went back to the Nurses Station and called a Code W. Z1 went and shut the alarm off. I did a head count and could' t find R3 and than I notified E8. E8 paged more CNAs and we all started looking inside and outside for R3."

8/18/05, 3:50 PM, interview with E10, nurse from B-wing, states "remembers hearing an alarm, and than it was off. Was not sure of the time. I thought it was 5:30 PM. I was down the B-wing hall and ran back to front by the A-B nurses station. The A-wing nurse, Z1, and a CNA were helping R3 back to his room. R3 was a couple of doors down the hall on the A-wing . I did not hear an alarm after that. I never heard a Code W called either."

8/19/05 interview with E13, nurse on B-wing stated "heard an alarm, heard several alarms that evening and wasn't sure where the alarm was coming from. I saw the nurse sitting at the A-wing nurses station, so went to the day room, to check for the alarm. A female resident was at the patio door, and I redirected her away from that door. I did not check the A-wing door. R3's family had come to me looking for him. I had seen R3 two times earlier and redirected him back to his room after dinner. I checked the day room for him."

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F9999	Continued From page 17 8/22/05, 10:30 AM, interview with Z2, Attending Physician, he stated: "this resident cannot go out in the community by himself. He's blind. He does need supervision when out on pass. The resident was evaluated at the hospital emergency room and he was fine. No injuries noted. The emergency room cleared him. I saw him and there was nothing new, did some blood work, and he's OK." Review of facility policy " Wandering and Missing Resident Policy" includes these statements: "all staff except the front door monitor are to immediately report to the sounding door. If no resident is noted by the sounding door, staff must immediately search the the outside gounds, and immediately begin an inhouse head count for each and every resident". Although , the staff interviewed agreed they had assisted in searching for R3 once they realized he was missing, there was some some confusion as to which door alarms were going off, some apparently didn't hear alarms, or the code W being called. There seemed to be a delay in responding to the alarms, and all interviewed did not immediately search the outside area of the alarmed door.	F9999		