| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145507 | A. BUILDING ______ B. WING ______ | C 01/11/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLARK MANOR CNV CENTER | 7433 NORTH CLARK STREET CHICAGO, IL 60626 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 324 | Continued From page 3<br>locating a lost resident.<br>5) The Administrator and DON will monitor the above concerns on a every 24 hr schedule. | F 324 | | |
| F9999 | FINAL OBSERVATIONS<br><br>Licensure Violations<br><br>300.1210a) 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.<br><br>300.1210b)4) Personal care shall be provided on a 24-hour, seven-day-week basis.<br><br>300.3100d)2) 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.<br><br>Based on record review, resident interview and staff interview the facility failed to provide adequate supervision to prevent the elopement of one resident (R2) from a "locked" unit, and out the facility door. R2 also had an electronic wrist alarm unit on her person. This unit did initiate the door alarm to go off, but facility staff did not | F9999 | | |

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| F9999 | Continued From page 4 | F9999 | | |

respond to this alarm, when told that a resident ( R2) did leave the facility.

Findings include:

R2 is diagnosed with Schizophrenia, COPD, Osteoporosis, Basal Cell CA and PUD. R2 is currently on medications including Risperdal and Ativan.

Per review of nurse notes dated 11/27/05, R2 was restless and was attempting to leave the facility. R2 was given Ativan and an electronic wrist alarm device was placed on her left wrist. At this time R2 was considered an elopement risk. R 2 was also transferred to the 3rd floor (from the 2 nd floor). This floor is a "locked" unit. There is no alarm on the 3rd floor elevator to alert staff if elevator is used by the resident.

On 12/05/05 nurse notes and the incident report state that the receptionist called the 3rd floor at approximately 4:30 A.M. The receptionist stated a resident walked out the south entrance on the first floor. The wrist alarm device had gone off at this south entrance location. The receptionist failed to stop the resident even though the alarm went off. Instead she called the 3rd floor . The 3rd floor did a head count instead of acting immediately to retrieve the resident. According to nurse notes and incident report, the facility determined that the resident was in fact missing. At approximately 6:30 A.M. the Chicago Police brought back the resident. She was found at Devon and Clark approximimally 2.0 Hrs after leaving. There was no injury to the resident.

Documents were reviewed. R2's P.O.W.

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| F9999 | Continued From page 5 states she is to have an electronic wrist alarm on her. R2 is care planned for elopement risk and the alarm is mentioned in the care plan<br><br>During the investigation on 12/23/05 R2 was interviewed. R2 is confused. R2 stated she went for a walk on the day that this elopement took place. R2 stated she did not get hurt at this time. During this interview R2 did not have an electronic wrist alarm on her wrist. The P.O.W. shows she is supposed to have a wrist alarm on. E4 was interviewed. E4 responded that she put R 2's wrist alarm on her after the above observation . E5 was interviewed and responded that R2 takes her electric monitoring device off and it has to be put back on.<br><br>After many attempts the receptionist was interviewed by phone at 1:00 PM on 01/09/06. E 6 (receptionist) stated she does not remember specific dates or times. R6 was sitting at the nurses station on the 1st Floor. This is where the receptionist sits during the construction of the new entrance. R6 was in the washroom at the 1st floor nurses station when she heard the personal device monitoring alarm go off . R6 exited the washroom and looked out the south entrance ( used as the main entrance at this time)and did not see a resident. She then called the 3rd floor and 2nd floor nurses station to tell them the alarm went off. These floors then initiated a head count to determine if a resident eloped. Shortly after, the Chicago Police brought R2 back into the facility after they found her out on the street. The above statements are how R6 responded. The above interview statement is not onsistent with what the incident report states. | F9999 | | |

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| F9999 | Continued From page 6<br>(A) | F9999 | | |