STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E168	A. BUILDING _____ B. WING _____	C 07/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINCREST NURSING CENTER CORP	**6326 NORTH WINTHROP AVENUE CHICAGO, IL 60660**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 5 request to release wires" from the keypad and with handheld remote switches. New combination numbers will be assigned and kept confidential with security staff and the administrator. Both the maintenance engineer and the administrator will do daily checks to ensure all locking devices and door bells are functional. Those needing repairs will be done promptly 5. The house supervisor who is supposed to be on duty at the time R2 went AWOL was terminated and interviews are being conducted to hire a new house supervisor on the evening shift. The administrator will make unannounced unscheduled visits to the facility at different hours of the day , nights and on weekends to ensure all AWOL policies and procedures are being performed by Wincrest staff members. The Director of Nurses will do late night inspections after midnights to ensure compliance 6. The Maintenance Engineer and the administrator will review and report the proper implementation of the new AWOL protective measures and its outcome, to the Interdisciplinary Quality Assurance Committee. This committee will oversee and guarantee the continuing safety and wellbeing of all residents of Wincrest Nursing Center on AWOL precaution. 7. The Care Plan coordinator and the IDT will review and develop measurable goals for each resident on AWOL precautions utilizing the newly developed protective measures being implemented, in order to guarantee their safety and security.	F 324		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 6 Licensure Violations: 300.1210 a) 300.1210 b)6) 300.1220 b)3) 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. Restorative measures shall include at a minimum the following procedures: b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as	F9999		

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F9999	Continued From page 7 nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements are not met as evidenced by : Based on observation, interviews and record review the facility failed to provide supervision and monitoring to one confused resident (R2) who was assessed as an elopement risk. This resulted in R2 leaving the facility unsupervised at 6/18/06 at an undetermined time at night. R2 was found by the police and was brought to Cook County Hospital where he was hospitalized for several days. Findings include: R2 is a 76 year old male with the following diagnosis: Dementia, Undifferentiated Schizophrenia, Anti-Social Personality, Arteriosclerotic Heart Disease, Diabetes Mellitus, Parkinson Syndrome, Chronic Obstructive Pulmonary Disease, Gastritis and General Weakness. R2's current MDS (Minimum Data Set) scores 3 (severely impaired) for cognitive status. Current care plan dated 5/1/06 states the resident's care needs are: Problem: "poor memory, easily confused & forgetful. He has a history of AWOL (absent without leave)." Goal: "No incidence of AWOL and going out by self." The Plan does not	F9999		

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F9999	Continued From page 8 specifically address what measures are to be implemented to prevent the resident from leaving the facility. R2 was also considered a smoking level 2 risk. R2 is to be given one cigarette and matches to smoke 1 on 1 while a staff supervises . (This was determined from review of smoking policy and interview of E2). An incident report dated 6/18/06 states that R2 was not in his bed when E3 (C.N.A - Certified Nursing Assistant) made rounds at 11:00 P.M. A search was done inside and outside the building, then 911 was called and a missing persons report filed with the police. R2 was interviewed on the 2nd floor in the activity room on 7/14/06 at 10:40 A.M. R2 was asked why he left the facility? R2 responded he left the facility when he went to smoke. R2 said he went to "see the president." R2 was asked where he stayed when he was out. R2 responded "in hotels ." This was the only information R2 gave to surveyor and R2 became increasingly agitated when asked more questions. E2 (D.O.N.-Director of Nurses) was interviewed on 7/14/06 at 11:00 A.M.. E2 stated that during a room check at 11:00 P.M. by E3, R2 was not in his room. E3 notified E2 by phone and initiated a facility search with other staff. The exterior of the facility was searched. Police were notified and a missing person was filed. E1 was interviewed on 7/20/06 at 11:30 A.M. in the social service office. E1 responded that he interviewed the guard (E4), who was supposed to be at the front door of the facility on 6/18/06 when R2 eloped. E1 stated E4 responded that he let R 2 out onto the front patio to smoke "about 10:00 P.M." E4 then told E1 that he failed to monitor R	F9999		

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F9999	Continued From page 9 2 while outside smoking at that time of night. The next day E1 sent out a fax to all hospitals in the area notifying them of the elopement and condition of the resident. On 6/26/06 "someone" from the county hospital read the fax and called E 1 and stated she was sorry but they had admitted R2 and had not been given any history from the resident and did not know he had eloped from the nursing home. E1 did not have a specific name of who he talked to at the hospital when it was requested by surveyor (at time of interview). By this time R2 had missed several doses of routine medications and twice daily dose of insulin injections and accucheck monitoring. R2 was readmitted back to nursing home on 6/27/06 and put on 1:1 monitoring. E7 (front entrance guard) was interviewed by phone on 7/24/06 at 9:20 A.M. E7 responded that he "escorted" R2 out to the front patio to smoke a cigarette at 10:30 P.M. E7 told R2 to " come back into the facility when he was finished." E7 returned to his front entrance post. E7 stated that he saw R2 return into the facility and walk past him. E7 never saw R2 after this. Around 11: 00 P.M. staff asked him if he saw R2 and that R2 was missing. E7 was not aware that R2 was an elopement risk and that he needed close supervision while smoking. E7 also stated that there are supposed to be two guards on duty from the 4 to 2 shift. The other guard did not show up to work that day . E7 stated that the other guard assisted him in keeping the building and residents secure. Surveyor could not determine who gave R2 the smoking materials and failed to supervise him. On 6/27/06 at 6:00 P.M. R2 was returned to the facility by ambulance.. E2 stated he was brought	F9999		

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F9999	Continued From page 10 back without injury E2 also stated R2 has never eloped from the facility before since she has been working here. (5 yrs) On 6/20/06 Z-1 (Medical Dr) was interviewed by phone from the facility at 1:53 P.M. Z1 stated that R2 was fine when he was brought back to the facility. There was no injury or medical complications when Z1 saw R2 ,after being returned to the facility. (R2 had spent several days as an in patient at the hospital getting stabilized.). The County Hospital Discharge Summary was reviewed. This form states that R2 was admitted to the hospital on 6/23/06 and discharged on 6/27/06. R2s whereabouts have not been determined from 6/18/06 until 6/23/06. (A)	F9999		