STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145947	A. BUILDING _____ B. WING _____	C 12/14/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA TERRACE	**3249 WEST 147TH STREET MIDLOTHIAN, IL 60445**

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F 323	Continued From page 5 RN/LPN/CNA will be responsible for hourly rounds. There are 4 residents have been identified as having potential for elopement. 3.) Care Plans will be developed for the identified elopement risk residents. 4.) Identification Bands will be instituted. 5.) Electronic Monitoring Device will be obtained to prevent elopement. 6.) A Directed Inservice given today to all employees along with the Medical Director and QA Committee (which consist of Administrator, Director of Nursing, Housekeeping/Laundry Manager, Maintenance, Activity, Social Service and Dietary Managers) on elopement procedures. 7.) Directed Inservice to be repeated to all employees including QA Committee within the next 3 days	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.690a)1) 300.1210a) 300.1210b)6) 300.3100 d) 2) Section 300.690 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and	F9999		

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accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department.

1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number.

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:

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 300.3100 General Building Requirements

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F9999	Continued From page 7 d) Doors and Windows 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. These REGULATIONS are not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to adequately supervise and monitor a confused resident identified as an elopement risk (R6). R6 left the facility without staff having knowledge of her leaving on 11/11/07 between 11:00 PM and 12:00 AM. R6 was picked up by Hazel Crest Police when notified by community when R6 was knocking on homeowners' doors. R6 was taken to nearby area hospital Emergency Room. The hospital ER staff notified the facility to pick up R6. R6 is cognitively impaired with poor judgment and is unsafe to go out without supervision. R6 travelled from Midlothian to Hazel Crest which is approximately 3-4 miles. R6 is also unable to identify the facility where she currently resides. Findings include: R6 is a 57 year old resident who was originally admitted to the facility on 12/17/03 and re-admitted on 4/22/07. R6 has diagnoses of Paranoid Schizophrenia and unspecified Essential Hypertension.	F9999		

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F9999	Continued From page 8 According to the Minimum Data Sheet (MDS) dated 8/19/07, R6 has memory problems and behavior symptoms identified as wandering 4-6 days per week. During the tour of the facility on 12/7/07 between 12:00 PM and 2:00 PM., R6 was in the dining room of Unit II. R6 is alert and oriented to self only. R6 is confused and disoriented to time, place, and person. No electronic monitoring device to prevent elopement was seen attached to R6. The facility is a single story structure with two interconnected wings. The facility is located along a busy street. All resident rooms are at a ground level. R6's room is located in Unit I. There are 5 exit doors with keypads and automatic alarms. A central station box is located on each nursing station unit which lights up when an exit door is breached. Copies of the facility's door systems service report, including door alarm, did not show that the alarm system is checked regularly for proper functioning. Review of R6's clinical record indicated that on 4/22/07 the resident was found walking on the street alone. At that time, R6 was under the care of the brother. Facility staff picked up R6 from the Police Station, and R6 was taken to a hospital for examination. R6 was re-admitted to the facility on the same day from the hospital. The record did not contain any documentation of additional safety measures to ensure the resident's safety or to prevent an elopement. Review of the nursing care plan did not address any elopement risk.	F9999		

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Review of the Incident Report dated 11/11/07 did not contain information that the Facility Medical Director was notified of the incident. Facility's initial investigation on 11/12/07 did not show the events leading to the elopement.

During interviews with E1 on 12/7/07 and 12/14/07, E1 stated she was made aware of the elopement incident involving R6 on 11/11/07. However, R6 was not placed on an elopement list nor was an electronic monitoring device used to prevent elopement.

The administrator stated that she had several encounters with R6's brother who wanted to take R6 out of the facility against medical advice. She also stated that the brother had taken R6 out of the facility without the proper sign-out documentation. E1 also stated that the facility legal counsel advised R6's brother to petition for guardianship, however the brother has not done so.

E1 also stated that the facility is looking into a state guardianship petition on behalf of R6. E1 further stated that, at the time of the elopement, the exit door alarms were all functioning. However, E1 confirmed that the sound emitted by the alarm is not loud and long enough to alert the staff. E1 also stated that no staff is assigned to monitor the exit doors.

E1 stated the elopement incident report was faxed to IDPH on 11/12/07. However, no such report was received.

During an interview with Director of Nursing (DON/E2) on 12/13/07, E2 stated she was made aware of R6's elopement when she was picked

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up from the hospital. E2 stated R6 was not placed on an elopement list nor was an electronic monitoring device used. However, E2 further stated all residents are placed on an elopement risk protocol. E2 stated that during the investigation she was not able to determine how R6 was able to leave the facility without the staff's knowledge.

During an interview with Unit I Charge Nurse (E6) on 12/7/07, E6 stated that she was unaware of any elopement incident involving R6 on 11/11/07. E6 also stated she was not sure if R6 was placed on an elopement list.

An interview with LPN (E8) was conducted on 12/14/07 at 9:45 PM. E8 stated he was on duty 11 PM-7 AM on 11/11/07. He was making rounds at 12:00 AM when he was unable to locate R6. E8 stated he immediately started looking from room to room, hallways, and bathrooms.

At 12:25 AM on 11/12/07, he received a call from the nearby area Hospital Emergency Room (ER) to pick up R6. The ER staff stated R6 was dropped off by Hazel Crest Police after being seen wandering in the neighborhood. E8 then picked up R6 from the hospital, and R6 was brought back to the facility at 1:05 AM on 11/12/07.

E8 further stated that R6 appeared okay and without visible injury. E8 stated R6 was dropped off by the brother that night between 9:00 PM and 10:00 PM. E8 also stated that the facility has had several encounters with R6's brother regarding taking R6 out of the facility without properly signing out or notifying facility staff.