STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145714	A. BUILDING ______ B. WING ______	C 04/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK HEALTHCARE CENTER	**625 NORTH HARLEM OAK PARK, IL 60302**

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F9999	FINAL OBSERVATIONS	F9999		

LICENSURE VIOLATIONS

300.1210a)
300.1210b)4)
300.1210b)6)
300.3240a)

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.
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 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regulations are not met, as evidenced by the following:

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F9999	Continued From page 8 Based on record review and interview, the facility failed to adequately supervise a resident (R2), who the facility identified as a wanderer with a tendency to leave the facility, and with a history of multiple falls. This failure to supervise and monitor the resident on 2/27/08, resulted in an undetected elopement and an incident fall with injuries requiring a hospital emergency room admission. Findings include: R2 is a 49 year old male admitted to the facility on 6/12/03, with admitting diagnoses that include: Seizure Disorder, OBS (Organic Brain Syndrome) and Dementia. R2 also had a history of Craniotomy. Review of R2's latest Annual Full Assessment dated 6/11/07 and Quarterly Review Assessments with the latest date of 3/5/08 showed the following : Cognitive Skills for Daily Decision Making scored (2) Moderately Impaired - decisions poor; cues / supervision required. Behavioral Symptoms Wandering - scored (1/1) Behavior of this type occurred 1 to 3 days in last 7 days. Behavior was not easily altered. Functional Limitation in Range of Motion Arm, Hand, Leg and Foot - scored (1/1) Limitation on one side, partial loss Facility Quarterly Assessment dated 12/5/07 indicated that R2 under "Accidents" had a fall in the past 31 to 180 days.	F9999		

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Continued From page 9

Review of Care Plans as documented:

12/12/07 Problem: Identified wanderer
Related To: Dx (Diagnosis) of Dementia
All Staff: Watch resident thru out the day to ensure comfort and safety.

Goal: Secure environment with no episodes of elopement thru staff monitoring and interventions.

Review of Facility Fall Risk Assessment on R2 as dated:

2/14/08 - scored 16
3/5/08 - scored 20

"Total score of 10 or above represents HIGH RISK"

Review of Facility Incident/Accident Reports on R2 documented the following incidents:

On 2/14/08 at 7:30PM:

" Resident was in dining room sitting in his wheelchair and he stood up and passed out, fell to floor hit his head. Rt (right) temple swelling. " Above incident was witnessed by another resident, and R2 was sent out to ER for evaluation according to records.

On 2/20/08 at 2:00 PM:

"Resident fell out of wheelchair in smoke rm. (room) he was observed by staff. no loss of consciousness." According to records, R2 had injury to upper lip.

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F9999	Continued From page 10	F9999		

Statement of Staff
"A resident call out while entering the smoke room that (R2) was on the floor. It was around 2 pm."

" (R2) was found on floor in smoke room. "

On 2/27/08 at 7:00 PM:

"CNA- Certified Nurses Assistant (E6) noticed (R2) was missing, she informed nurse and a full facility search was done. Facility search surrounding area of the facility and did not found R2. Police was notified of missing, Police informed facility that they had found R2, and had him send to hospital due to laceration to R (right) eyebrow. "
Elopement Incident description as above was signed by E1.

Staff interviews (E1-Administrator, E2- DON, E4-Receptionist, E5-CNA, E6-CNA) on 4/11/08, regarding the elopement incident of R2 on 2/27/08 showed the following:

E5 stated that around dinner time at 5:00PM, she saw R2 by the elevator and asked R2 what he was doing on the 1st floor. Then she instructed R2 to go back up to the floor, and had seen him get back to the elevator. Then she had overheard them announcing that they are looking for R2.

E6 stated that R2 is supposed to be in a wheelchair all the time. She had noticed R2 was not in his wheelchair that was parked by the smoking room at about 7:00PM to 7:15PM. She then told the nurse that was passing medications at the time. They searched the building and surrounding area, but R2 was not found. They

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F9999	Continued From page 11 were later told that the police had found R2 and he was sent to the hospital. E4 stated that R2 had left the building without her noticing him, and that it was very busy that evening towards the end of her 4 hour shift (4PM to 8 PM). The following day she was informed that R2 had slipped and fell. E4 further stated, "It was cold and icy that day." E2 stated that R2 returned to the facility with injury of laceration to the right forehead, and that their concern was, "There should be a security and receptionist in the front." E2 further stated that she does not know whether the receptionist had called in sick or she was at lunch during the elopement. E2 also stated security makes rounds hourly. E1did the investigation, but they do not know how R2 eloped from the building. E1 stated, "The information I got is that he (R2) got out with the visitors. We are assuming he did not get out the back door as the alarms did not go off." E2 further told surveyor during this interview, that the security staff and the receptionist were issued disciplinary action. Review of facility staff witness statements from a CNA and the security staff showed that R2 was seen in his wheelchair by the 1st floor main elevator lobby area with his coat on between 6:00PM and 6:30PM. Review of Hospital ER records showed that R2 was taken by the local Police to the ER, and was admitted on 7/27/08 at 7:51 PM. ER Triage documented: "Found by Police walking with hematoma and	F9999		

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F9999	Continued From page 12 dried blood to head and R (right) eye. Homeless here per EMS (Emergency Services)." R2 had diagnostic impression according to ER records as follows: "Fall/Seizure disorder." R2 had two other incident falls after 2/27/08 according to records review: 3/2/08 at 6:35PM Location : Hallway "Resident was sitting in wheelchair, leaned forward and slid out of chair to floor, R (right) side of head was pressing on floor, small amount of blood came from previous wound." 4/3/08 at 1:45 AM Location: Resident's room "Resident observed on the floor, near his bed, 3cm laceration noted to left eyebrow, also a raise bump the size of a quarter noted." Incident dated 4/3/08 according to records, R2 was sent out to the hospital ER for evaluation. R2 was observed by the surveyor on 4/11/08 to be an alert but pleasantly confused resident, with answer to all the questions asked as stated: "Uh-huh." R2 was also observed with swelling over left and right eyebrows (more pronounced over the right eyebrow area), and with intact stitches over left eyebow. The facility was not able to present to the surveyor the fall reassessments and updates of care plans for all these falls on R2 as required for each incidents occurrence.	F9999		