STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145638	A. BUILDING _____ B. WING _____	C 07/15/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HLTH CR CTR-BLMNGDL	**165 SOUTH BLOOMINGDALE ROAD BLOOMINGDALE, IL 60108**

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F 000	INITIAL COMMENTS Complaint Investigation 0873128/IL36178 - F323 Complaint Investigation 0873145/IL36199 - F323 A partial extended survey was conducted. PIGGYBACK 0873438/IL36514 - F323 (8/4/08)	F 000		
F 323 SS=J	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide adequate supervision for 1 resident (R3) with a diagnosis of dementia and a history of exit-seeking behaviors. The facility failed to accurately assess the risk of elopement for 1 resident (R3) and failed to identify this resident in the Elopement Risk Book located at the receptionist's desk in order to provide the level of supervision necessary for this resident to prevent elopement. These failures resulted in R3 leaving the facility without staff knowledge and without staff identifying that she was missing from the building until the local police department called the facility. These failures resulted in an Immediate Jeopardy identified and called on 7/10/08 at 2:00 PM to E1	F 323		7/28/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 (Administrator). The Immediate Jeopardy began on 7/6/08 at 4:00 PM when R3 was was first noticed to be missing from the New Town Unit. The example includes: R3 is a 93 year old resident with Dementia who has an unsteady gait and uses a walker as her mode of locomotion according to documentation on the Minimum Data Set dated 6/6/08. R3 is at risk for falls, has poor hearing in both ears and displays exit seeking behaviors according to documentation on the Resident Assessment Protocols (RAPS) for Falls, Cognitive Loss-Dementia, Communication, Mood and Behavioral Symptoms dated 9/19/07. R3 tried to get out the front door, was confused and looking for her daughters according to nursing notes dated 10/9/07. On 2/10/08 according to documentation in the nursing notes, R3 was verbalizing that she wanted to go home. According to "Client Services" note dated 12/10/07, R3 "continues with episodes of wanting to die, crying, sad facial expression, neg statements and wandering...." The facility assess that R3 was "not a risk for elopement" according to documentation on the "Elopement/Wandering Risk Assessment" form dated 12/10/07 and 03/07/08. It was not clear where the information was gathered from to make these statements. On 7/6/08 R3 was noticed to be missing from the unit at approximately 4:00 PM according to the nursing notes dated 7/6/08. The nursing notes written by E13 (nurse) state that the Certified Nurses Assistant (CNA) couldn't find R3 on the unit. E13 documents that she called the Receptionist on duty (E6) and asked him to check the visitor's log. E13 writes that the	F 323		

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F 323	Continued From page 2	F 323		

receptionist described a resident and her daughter that was with her in the lobby. E13 thought that the receptionist knew what R3 looked like and so assumed that it was R3 and her daughter in the lobby. E13 documents that at 4:30 PM the supervising nurse called to ask them to do a head count because the police department called and informed them that they had found a resident. E13 again called the receptionist and found that the resident he was describing earlier was in a wheelchair and not a walker, and therefore was not R3. E13 writes that she then told the supervisor that R3 was missing.

E8 (CNA) was interviewed on 7/9/08 at 2:08 PM. E8 said that he was assigned to R3 for the 7 AM to 3 PM shift on 7/6/08. E8 said that R3 was very confused and was repeating, "I don't know, I don't know." E8 said he last saw R3 at approximately 2:15 or 2:45 PM sitting on the couch near the exit doors in the New Town Unit.

E9 (CNA) was interviewed on 7/9/08 at 4:02 PM. E9 was assigned to R3 for the 3 PM to 11PM shift on 7/6/08. E9 stated that on 7/6/08 at approximately 4:05 PM she noticed that R3 was missing from the unit and told the nurse (E13). E9 said that E13 rechecked the unit and then called the front lobby desk. E9 stated that E13 told her that R3 was in the front lobby with her family. E9 said that at approximately 4:30 PM the supervising nurse called the unit and requested a head count. E9 said that she went to the front lobby and outside and didn't see R3 anywhere.

E6 (Receptionist) was interviewed on 7/9/08 at 2:20 PM. E6 stated that on Sunday (7/6/08) at approximately 3:00 PM he received a call from

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F 323	Continued From page 3 E13 (nurse) asking if he had seen R3. E6 said that E13 told him that R3 could be with her daughter. E6 said that he saw a blonde-haired resident in the lobby with her daughter who was also blonde and told this to E13. E6 stated that he did not know what R3 looked like. E6 said that at approximately 4:55 PM the local police department called and asked if they were missing a resident. E6 said that he did not recall hearing the front door alarm go off in the afternoon on Sunday 7/6/08. E1 (Administrator) was interviewed on 7/9/08. E1 stated that they do not know for sure how R3 was able to exit the building. E1 confirmed that R3 was wearing an alarm system alert bracelet when she was found on 7/6/08. E1 stated that the alert bracelet should alarm when the resident passes through the exit doors of the New Town Unit into the Old Town Unit and when they pass through the exit doors of the Old Town Unit into the lobby/receptionist area. E1 stated that the alarm number pad on the wall in the Old Town Unit had been damaged about 2 weeks ago but that the system was still armed. E1 said that the staff would have to place 2 pens into the place where the star key and number 1 keys were on the pad in order to de-activate the alarm once it alarmed. E1 said that even though R3 was wearing an alert bracelet she was not at risk for elopement. E1 stated that for this reason R3's picture was not in the Elopement Risk Book located at the receptionist's desk. E2 (Director of Nursing) was interviewed on 7/9/8 at 3:00 PM. E2 stated that R3 was not at risk for elopement based on nursing documentation and social service notes. E2 confirmed that there was no formal elopement assessment completed	F 323		

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F 323	Continued From page 4 on R3. Z5 (Local Fire Department Employee) was interviewed on 7/9/08 at 11:40 AM at the Fire House. Z5 said that on Sunday (7/6/08) at approximately 4:00 PM R3 was found wandering with her walker in the front driveway of the Fire House. Z5 stated that R3 was confused and said she was lost and wanted to kill herself. Z5 said that R3 had an alarm device around her ankle. Z5 said that the police department was notified. Z1 (R3's Physician) was interviewed on 7/10/08 at 2:35 PM. Z1 stated that R3 is very demented and is not able to make safe decisions. Z1 said that R3 requires supervision. The distance between the nursing facility and the fire house where R3 was found is approximately 0.2 miles and requires walking along a busy 4 lane road. R3 was observed on 7/10/08 at 1:05 PM in the New Town Unit. An attempt was made to interview R3 at this time but R3 kept repeating "I don't know" whenever a questioned was asked. The Immediate Jeopardy was removed on 7/9/08 after the facility took the following actions to reduce the severity to Level 2: 1) On 7/7/08 all staff were in-serviced on the facility's policies and procedures for missing residents. 2) On 7/7/08 elopement assessments were reviewed and revised for all residents and appropriate interventions initiated or continued.	F 323		

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F 323	Continued From page 5 3) All residents identified as being at risk for elopement were assessed and their individual needs were care planned. Random spot checks were initiated and will continue for 4 weeks and will e reviewed for any patterns during the quality assurance meetings. 4) All nursing staff were in-serviced regarding completing the facility's elopement risk assessment and their assessment skills were verified. 5) All staff in-serviced on identifying any residents who are attempting to leave the building. 6) The facility's policy and procedures regarding elopement were updated. 7) A quality assessment tool was developed that will be used to monitor regular testing of its alarm alert system and code alert bracelets. The testing will be done daily for 4 weeks and then re-evaluated. The Administrator will monitor for compliance. Above completed by 7/9/08.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1210b)6) 300.1220b) Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 6 a) 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care requried and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) 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. These requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to provide adequate supervision for 1 resident (R3) with a diagnosis of dementia and a history of exit-seeking behaviors. The facility failed to accurately assess the risk of	F9999		

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F9999	Continued From page 7 elopement for 1 resident (R3) and failed to identify this resident in the Elopement Risk Book located at the receptionist's desk in order to provide the level of supervision necessary for this resident to prevent elopement. These failures resulted in R3 leaving the facility without staff knowledge and without staff identifying that she was missing from the building until the local police department called the facility. Findings include: R3 is a 93 year old resident with Dementia who has an unsteady gait and uses a walker as her mode of locomotion according to documentation on the Minimum Data Set dated 6/6/08. R3 is at risk for falls, has poor hearing in both ears and displays exit seeking behaviors according to documentation on the Resident Assessment Protocols (RAPS) for Falls, Cognitive Loss-Dementia, Communication, Mood and Behavioral Symptoms dated 9/19/07. R3 tried to get out the front door, was confused and looking for her daughters according to nursing notes dated 10/9/07. On 2/10/08, according to documentation in the nursing notes, R3 was verbalizing that she wanted to go home. According to "Client Services" note dated 12/10/07, R3 "continues with episodes of wanting to die, crying, sad facial expression, neg statements and wandering...." The facility assessed that R3 was "not a risk for elopement" according to documentation on the "Elopement/Wandering Risk Assessment" form dated 12/10/07 and 03/07/08. It was not clear where the information was gathered from to make these statements. On 7/6/08 R3 was noticed to be missing from the	F9999		

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F9999	Continued From page 8 unit at approximately 4:00 PM according to the nursing notes dated 7/6/08. The nursing notes written by E13 (nurse) state that the Certified Nurses Assistant (CNA) could not find R3 on the unit. E13 documented that she called the Receptionist on duty (E6) and asked him to check the visitor's log. E13 wrote that the receptionist described a resident and her daughter that was with her in the lobby. E13 thought that the receptionist knew what R3 looked like and so assumed that it was R3 and her daughter in the lobby. E13 documents that at 4:30 PM the supervising nurse called to ask them to do a head count because the police department called and informed them that they had found a resident. E13 again called the receptionist and found that the resident he was describing earlier was in a wheelchair and not a walker, and therefore was not R3. E13 writes that she then told the supervisor that R3 was missing. E8 (CNA) was interviewed on 7/9/08 at 2:08 PM. E8 said that he was assigned to R3 for the 7 AM to 3 PM shift on 7/6/08. E8 said that R3 was very confused and was repeating, "I don't know, I don't know." E8 said he last saw R3 at approximately 2:15 or 2:45 PM sitting on the couch near the exit doors in the New Town Unit. E9 (CNA) was interviewed on 7/9/08 at 4:02 PM. E9 was assigned to R3 for the 3 PM to 11PM shift on 7/6/08. E9 stated that on 7/6/08 at approximately 4:05 PM she noticed that R3 was missing from the unit and told the nurse (E13). E9 said that E13 rechecked the unit and then called the front lobby desk. E9 stated that E13 told her that R3 was in the front lobby with her family. E9 said that at approximately 4:30 PM the	F9999		

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F9999	Continued From page 9 supervising nurse called the unit and requested a head count. E9 said that she went to the front lobby and outside and did not see R3 anywhere. E6 (Receptionist) was interviewed on 7/9/08 at 2:20 PM. E6 stated that on Sunday (7/6/08) at approximately 3:00 PM he received a call from E13 (nurse) asking if he had seen R3. E6 said that E13 told him that R3 could be with her daughter. E6 said that he saw a blonde-haired resident in the lobby with her daughter who was also blonde and told this to E13. E6 stated that he did not know what R3 looked like. E6 said that at approximately 4:55 PM the local police department called and asked if they were missing a resident. E6 said that he did not recall hearing the front door alarm go off in the afternoon on Sunday 7/6/08. E1 (Administrator) was interviewed on 7/9/08. E1 stated that they do not know for sure how R3 was able to exit the building. E1 confirmed that R3 was wearing an alarm system alert bracelet when she was found on 7/6/08. E1 stated that the alert bracelet should alarm when the resident passes through the exit doors of the New Town Unit into the Old Town Unit and when they pass through the exit doors of the Old Town Unit into the lobby/receptionist area. E1 stated that the alarm number pad on the wall in the Old Town Unit had been damaged about 2 weeks ago but that the system was still armed. E1 said that the staff would have to place 2 pens into the place where the star key and number 1 keys were on the pad in order to de-activate the alarm once it alarmed. E1 said that even though R3 was wearing an alert bracelet she was not at risk for elopement. E1 stated that for this reason R3's picture was not in the Elopement Risk Book located at the	F9999		

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F9999	Continued From page 10 receptionist's desk. E2 (Director of Nursing) was interviewed on 7/9/8 at 3:00 PM. E2 stated that R3 was not at risk for elopement based on nursing documentation and social service notes. E2 confirmed that there was no formal elopement assessment completed on R3. Z5 (Local Fire Department Employee) was interviewed on 7/9/08 at 11:40 AM at the Fire House. Z5 said that on Sunday (7/6/08) at approximately 4:00 PM R3 was found wandering with her walker in the front driveway of the Fire House. Z5 stated that R3 was confused and said she was lost and wanted to kill herself. Z5 said that R3 had an alarm device around her ankle. Z5 said that the police department was notified. Z1 (R3's Physician) was interviewed on 7/10/08 at 2:35 PM. Z1 stated that R3 is very demented and is not able to make safe decisions. Z1 said that R3 requires supervision. The distance between the nursing facility and the fire house where R3 was found is approximately 0.2 miles and requires walking along a busy 4 lane road. R3 was observed on 7/10/08 at 1:05 PM in the New Town Unit. An attempt was made to interview R3 at this time but R3 kept repeating "I don't know" whenever a questioned was asked. (A)	F9999		