STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145006	A. BUILDING _____ B. WING _____	C 02/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA REHAB & LIVING CENTER	**1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505**

(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 323	Continued From page 4	F 323		
F9999	. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.2210a) 300.3100d)2) 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 300.2210 Maintenance	F9999		

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F9999	Continued From page 5 a) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies. Section 300.3100 General Building Requirements 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 were not met as evidenced by: Based on observation, Record Review, and Interview, the facility failed to monitor one resident (R1) who left an alarmed nursing unit on 12/03/08 approximately at 03:40am. Staff were not aware that R1 had left the unit. The facility further failed to maintain door alarms in functioning order and failed to implement the wandering risk protocol they had instituted for R1 who has a history of wandering. Findings include: R1's 12/2008 Physician Order Sheet (POS) documents that R1 has diagnoses that include Depressive Disorder and Intracranial Hemorrhage following injury. R1's admitting Minimum Data Set dated 08/11/08 assessed R1 as having a short term memory problem. For Activities of Daily Living, R1 is moderately cognitively impaired, and supervision is required.	F9999		

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F9999	Continued From page 6	F9999		

He was also assessed as having a behavioral symptom of wandering. A Resident Assessment Protocol entitled Behavior documents that R1 "wanders throughout the unit and seeks the exit." R1's Nursing Notes between 10/03/08 and 12/03/08 document that R1 is confused, easily agitated, and wanders into other resident rooms. During a confidential interview with a staff member, it was noted that R1 was often exit seeking, but was redirected prior to leaving the unit. During a phone conversation with Z2, a physician, it was stated that R1 is not safe in the community alone. His safety awareness is poor. During private conversations with staff members it was stated that R1 often wandered at night, was often verbally aggressive with staff, easily agitated, and frequently asked directions to his room.

R1's Nursing Notes dated 12/03/08 note that R1 left through an exit door at the end of hallway that led to the patio. He was found about 25 minutes later with no apparent injury.

R1's room was the last room down the hallway from the Nurses' Station. His room was close to the outside exit which was directly around the corner from R1's room, which facilitated an unseen exit and made monitoring a resident who is an elopement risk more difficult.

Z1 was interviewed over the phone on 01/16/09 at 10:00am. During the conversation it was stated that he drives a medivan, and picks up residents about 3:30am daily. On 12/03/09 at about 3:40am he observed a man outside walking only in a T-shirt and pants. He immediately informed the facility about the man. The facility staff were unaware that a resident

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F9999	Continued From page 7 was missing. Z1 assisted in the search. Evidently R1 traveled on the side walk to a street about .3 miles away. R1 had stopped at a gas station and a convenience store, asking directions to Chicago. R1 traversed about .2 more miles east. At this point he was found.(about 3:55am.) He was then transported in the medivan to the facility. R1 appeared totally confused. The street in front of the facility has a speed limit of 35 miles per hour. Even at 4:00am the traffic is heavy, and trucks fly by. The National Weather Bureau reported the temperature on 12/03/08 at 04:00am was 31 degrees F with a wind chill of 22 degrees F. During a phone Conversation with E8, a nurse, it was stated that R1 was agitated prior to leaving the unit on the night in question and was asking about his "truck which was outside." E8 placed R1 on every 15 minute monitoring, but admitted that staff were "occupied with other residents." R1 was last observed about 3:30am. About 3:40am the exit door by R1's room was checked. It was found that the alarm was not functioning. Foot prints were noted in the snow outside the door. Door alarm monitoring sheets maintained by maintenance show the facility failed to check the alarms from 11/18/08 to 12/17/08, and this was validated by E9, the Facility's Director. (A)	F9999		