STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145828	A. BUILDING _____ B. WING _____	C 04/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENUE CARE CENTER	**4505 SOUTH DREXEL CHICAGO, IL 60653**

(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 7 10. Responsible staff on duty during the evening of this incident was terminated on March 30, 2009. 11. Random alarm response audit conducted. On-going. The Immediate Jeopardy was removed on 04/15/09. However the facility remains out of compliance at a severity level 2 to assure implementation of above plans.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 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)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.	F9999		

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F9999	Continued From page 8 These REGULATIONS were not met as evidenced by: Based on staff and resident interviews, and record review, the facility failed to assure that staff provide the necessary monitoring/supervision for 1 of 10 sampled residents (R2) who has been assessed as being a high risk for elopement. On 3/29/09 during the night shift, R2 left the facility undetected though two alarmed doors. Staff also failed to follow the established policy/procedure for responding to the activation of the emergency door alarm system. R2, who has diagnoses including Dementia and has been assessed by the facility as a high elopement risk, eloped from the 2nd floor of the facility at approximately 3:00AM using the back stairwell to the emergency exit activating two alarms. Interview and observation indicated that staff deactivated both alarms but did not follow the facility's policy and procedures regarding elopement. R2 was later found by the local police two blocks away near a well traveled intersection dressed only in a hospital gown. R2 was brought to the facility twice in a police squad car by the police officer seeking identification of R2. However on both occasions, staff did not identify R2 as a resident of the facility. R2 was then taken to a local hospital by the police officer and admitted to the Intensive Care Unit with a diagnoses of Hypothermia. The official temperature for the Chicago area for this	F9999		

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F9999	Continued From page 9 date had a recorded wind chill factor below zero with start of snow activity. Findings include: R2 is a 75 year old resident with diagnoses including Dementia, Schizoaffective, and Seizure Disorder. Upon admission to the facility R2 was assessed by the facility as high elopement risk and required staff assist/supervision in all areas of care except transfers. Incident report dated 03/29/009 indicated in part that at approximately 3:00AM, R2 was missing. "Resident out of facility, confused, night shift, injury unknown at this time, physician notified endorsed to day shift, awaiting r/t call family notified Family (DTR) called ..message left, awaiting return call. Notified by CPD (Chicago police department) possible resident taken to hospital. CNA (certified nurse assistant) went to hospital where later this resident was identified as an Avenue Care resident. Comprehensive investigation on-going." On 04/15/09 at approximately 3:05 PM, surveyor interviewed E1 (Administrator) and E3 (Director of Nursing) regarding R2's elopement. E3 stated, "R2 was discovered missing on 03/29/09 at about 3:00AM when R2 was brought back to the facility by the Chicago Police Department." E3 continued, "E4 (1st floor nurse) failed to identify R2 as our resident, so that police officer left with R2 in the car, but another police officer returned later with R2. E8 CNA (certified nurse assistant) went to the police car, but E8 too didn't recognize R2. So the police officer stated that he was taking R2 to the hospital."	F9999		

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F9999	Continued From page 10 Upon further interview E3 added, "It was cold and later snowed that morning. R2 was reportedly dressed in a hospital gown." E3 continued, "It was after the 2nd police left that E4 called the 2nd floor and discovered that R2 was missing. E7 (CNA) then drove her private car to the hospital and positively identified R2 as one of our residents. We got a call about 3:45AM about the incident." E3 finally stated, "R2 was admitted with a diagnosis of Hypothermia." E1 (Administrator) who was present during this interview added "We (E1 and E3) got here about 5:45AM and did an investigation and found out that R2 had exited the building using the 1st floor emergency exit." Upon further interview E1 added, "That exit door did alarm that night and even woke up two residents (R9 and R10)." E1 continued, "I inserviced staff about a month ago about responding to the alarm. E4 and E5 (charge nurse 2nd floor where R2 resided) attended. The staff should have called a Code Orange when the alarm went off." (Code Orange is the facility's code to notify staff of an elopement or attempt.) On 04/16/09 at 9:00AM, surveyor interviewed R9 (identified as alert and oriented) regarding the morning R2 eloped and hearing the alarm. R9 stated, "I remember hearing an alarm going off about 2:00 or 3:00 that morning about 3 weeks ago. I'm not sure about the time." R9 continued,"That alarm and exit door is near my room, so it woke me up." R9 continued, "I got up and walked up to the front desk, and I saw a	F9999		

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F9999	Continued From page 11	F9999		

male nurse (E4) doing something with the medication cart and he buzzed another CNA in who was at the front door." Upon further interview R9 added, "I'm not sure if they (E4 and the CNA) heard the alarm, nor do I remember who walked down and turned the alarm off, but later I did see a policeman come in the building."

Record review indicates that the facility has a missing resident elopement policy and procedures in part as follows:

1. Announce "Code Orange' (facility's code for elopement) over the PA system and conduct an in-house and outside search.

These procedures were not followed by the facility staff.

On 04/16/09 at approximately 8:40AM, surveyor with E3 toured the 2nd floor and inspected the exit door at the end of the hallway. R2's room was noted approximately 50-75 feet from the back exit door. This door was unlocked but upon pushing this door to open it, a loud alarm was activated. This alarm continued to sound loudly until E3 reached over head and pushed a black button that was located on the top opposite wall.

Upon interview E3 stated, "This is the only way to turn off that alarm (pointing to the black button). Someone has to push that black button to turn it off. R2 has Alzheimers.

Surveyor with E3 then proceeded down the back stairwell to the 1st floor emergency exit door (this door leads to the outside of the building to a cross street). This door too was unlocked, but upon pushing it open, a loud siren - sounding

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F9999	Continued From page 12 alarm was activated. E3 stated, "Staff would have to use a key to turn this alarm off since it is an emergency exit." E3 signaled for maintenance to come with the key to turn this alarm off. However after several minutes, maintenance, housekeeping staff was unable to turn the loud sounding alarm off. E9 (nurse on 1st floor) who was present during this time stated, "A nurse on this floor or maintenance has a key at all times to turn the alarm off." Upon further interview E9 stated, "The nurse or maintenance would have to walk all the way down the hallway and use the key to turn that alarm off. I don't know why the key is not working now. Approximately 20 minutes later the loud sounding alarm continued to alarm even though staff was trying to turn unit off. E1 who was present at this time stated, "This is a new, louder alarm system I had installed after R2 got out that night. I got staff at each exit now until I can get this alarm fixed." Upon further interview E1 confirmed "A key is kept at the 1st floor nurses station to turn off the alarm once it goes off." E1 added, E8 (Certified nurse assistant) said she heard the alarm and took the key and turned it off, but failed to call a "Code Orange and follow the policy as she should have." This interview and inspection by surveyor indicated that the morning R2 eloped from the facility, the alarm on the 2nd floor was activated but was deactivated by staff, as well the alarm at the emergency exit on the 1st floor was activated and staff had to physically walk down the long	F9999		

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F9999	Continued From page 13 corridor to deactivate this alarm using a key. Code Orange was never called, and the facility did not search inside and surrounding the building per policy. (A)	F9999		