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	145429	A. BUILDING _____ B. WING _____	C 05/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

(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 490	Continued From page 37 elopements were completed for all the shifts by the DON and or designee. In service also included risk for suicide and behavior interventions. -On May 5, 2009, a contractor came to the facility to evaluate window security on the Dementia Unit. -On May 6, 2009, staffing was readjusted to ensure 3 staff members are present on dementia unit for 3 to 11 PM shift and 11 to 7 am shift. -In service was conducted with department managers regarding staffing on the secured dementia unit and the need for three staff members on the unit at all times. -Staff on vacation or otherwise not on duty and new staff will be inservices on the above before they go on duty. -On May 6, 2009, a QA/QI monitoring tool to ensure residents with suicidal ideations were assessed and monitored by facility staff. Compliance will be monitored by the Administrator and Designee. -On May 6, 2009, a QA/QI monitoring tool was developed to ensure adequate staffing is in place on the the secured dementia unit. Compliance will be monitored by the Administrator. -On May 6, 2009, a QA/ monitoring tool to ensure residents with elopement ideation receive appropriate interventions by facility staff. compliance will be monitored by Administrator, Director of Nursing and Dementia Unit Coordinator.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a)	F9999		

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F9999	Continued From page 38 300.1210b)3) 300.1210b)6) 300.1230a) 300.1230c) 300.3240a) 300.7020a)1)3)4) 300.7020b)2) 300.7050b) 300.7050c) 300.7050d) 300.7050e) 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the in the resident's medical record. 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 39 Section 300.1230 Staffing a) Staffing shall be based on the needs of the residents, and shall be determined by figuring the number of hours of nursing time each resident needs on each shift of the day. This determination shall be made separately for both licensed and nonlicensed nursing personnel. c) It is the responsibility of each facility to determine the staffing needed to meet the needs of its residents. 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) Section 300.7020 Assessment and Care Planning a) Resident assessments, in addition to requirements in other applicable State and federal regulations, shall include a standardized, functional, and objective evaluation of the resident's abilities, strengths, interests, and preferences. The assessment shall be completed within 14 days after admission. 1) Assessments shall include at least a behavioral and a functional assessment, as well as direct observations of the resident. The facility shall attempt to interview the resident, the resident's family, the resident's representative, and recent and current direct care givers. This attempt shall be documented. 3) Assessments shall be conducted by a nurse, physical therapist, occupational therapist, social worker or unit director who has at least two years	F9999		

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F9999	Continued From page 40 of experience working with residents with dementia and who has training in conducting behavioral or functional assessments 4) The assessment process shall be ongoing by direct care staff or other professionals, as needed, and shall include the assessment components in subsection (a)(2). b) The care plan shall be developed by an interdisciplinary team within 21 days after the resident's admission to the unit or center. The interdisciplinary team shall include, at least, the attending physician, a nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, the resident, the resident's representative, and the certified nursing assistant (CNA) who is primarily responsible for this resident's direct care, or an alternate, if needed, to provide input and gain insight into the care plan. Others may participate at the discretion of the resident. 2) As new behaviors manifest, the behaviors shall be evaluated and addressed in the care plan Section 300.7050 Staffing b) The unit shall have assigned, consistent staff. There shall be enough staff to meet the scheduled and unscheduled needs of each resident, as defined in the care plan, taking into account the purpose of the setting, the severity of dementia, and the resident's physical abilities, behavior patterns, and social and medical needs. c) All staff who ever work on the unit (e.g., nurses, CNAs, housekeepers, social services and activities staff, and food service staff) shall receive at least four hours of dementia-specific	F9999		

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F9999	Continued From page 41 orientation within the first 7 days of working on the unit. d) Nurses, CNAs, and social service and activities staff who work on the unit at least 50 percent of the time that they work at the facility shall participate in a minimum of 12 additional hours of orientation within the first 45 days after employment, specifically related to the care of persons with Alzheimer's disease and other dementia. This orientation shall be defined in facility policies and procedures; shall be in a form of classroom, return demonstration, and mentoring; and shall define to new staff the elements contained in Section 300.7050(e)(1)-(10). e) Nurses, CNAs, and social services and activities staff who work on the unit at least 50 percent of the time that they work at the facility shall attend at least 12 hours of continuing education every year, specifically related to serving residents with Alzheimer's disease and other dementia. (Completion of the 12 hours of orientation in accordance with subsection (d) of this Section may be counted as continuing education for the year in which this orientation is completed.) . These requirements are not met as evidenced by on the following: Based on interviews and record reviews, the Administration failed to ensure that the Alzheimer's/Dementia Unit was staffed with adequate numbers of trained staff. Administration failed to ensure that the facility's policy for Alzheimer's/Dementia Unit training was followed and staff working on the unit had the	F9999		

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F9999	Continued From page 42 required 4 hour training course. The administration failed to ensure that staff was knowledge of the interventions and methods to control R1's behavior that included wandering, pacing and attempting to elope from the facility. This failure resulted in R1 attempting to leave the facility and jumping from the window, resulting in R1's death. Findings Include: R1 was a 84 year old male with diagnoses includinf Alzheimer's, Dementia, Impaired Vision, Glaucoma and Diabetes Mellitus. R1 ambulated with a cane. R1 was alert and orientated times two. The resident was readmitted on 4/25/09 from the hospital with a diagnosis of Altered Mental Status. The Endurance/Functional Ability Assessment dated 04/14/04 stated, "Resident has behavioral episodes during late after noon and sun downing." The nursing documentation from 4/7 - 5/4/09 show 19 episodes of R1 pacing, wandering, being agitated, stating he wanted to leave, packing suitcases, entering other residents' rooms to pack their suitcases, and attempting to leave through the alarmed exit doors. The nurse notes dated 05/04/09 state: 9:00 AM: "resident on unit. Frequently requesting to go home" 2:00 PM: "Resident ambulating frequently on unit with walking cane. Resident is asking this writer (E5- Nurse) for a bus pass, stating 'I want to go home.' Resident informed that he live here at the facility".	F9999		

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F9999	Continued From page 43 4:00 PM: "resident noted agitated and continuously stating," I want to go to the bus -stop" attempted to leave the unit. 4:40 PM: "per CNA (Certified Nursing Assistant) resident observed still to be agitated and in another resident's room bothering a co -resident (R6). Attempted to redirect resident unsuccessfully Security called to floor. 4:45 PM: "Security on unit, able to persuade out of co residents room. Security remained with resident until calm." 5:30 PM "Security staff escorted resident to the day room, with no signs of agitation at this time." 5:40 PM "Per CNA staff resident left dining area and began pacing." 5:45 PM "Rounded unit unable to locate resident." 5:53PM: "Responded to the emergency call, emergency cart brought to area. Noted resident in supine position with both legs extended . Resident unresponsive to verbal or facile stimuli. Unable to palpate pulse. Quick neuro assessment both pupils dilate and airway assessed Cardio -Pulmonary Resuscitation started." The initial Social Service note dated 04/14/09 denoted: "R1 is a new admit to the Pathway Dementia Care Unit under the care of Z3. It is observed by family and, doctors, and staff that R1 exhibits long and short term memory deficits and needs daily supervision. He ambulates but appears to have a unsteady gait at times. R1 appears to be happy person but not pleased with being placed in the facility, he also appears to be angry with daughter regarding to placement. Due to confusion and vision deficits, need cues and prompts and encouragement. R1's has repetitive	F9999		

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F9999	Continued From page 44 questions at times concerning having to leave facility." On 05/04/09, E4 (Alzheimer/Dementia Unit Coordinator) documented the following in the social service notes, "(writer (E4) heard R1 telling staff he wanted "to go home" as he was coming out of the day room about 3:15 PM and "get on the bus." Writer got up and asked resident what was wrong. He stated," I am getting out of here, I don't want to talk to you." Writer asked R1 to please go with her stating she understands and wanted to help him. He then walked and talked with writer and was calming down a little, still stating he's not staying. He refused to let writer assist with care/cueing. Writer called for his Certified Nurse Aide (CNA) and told her that I would get the other CNA to come help, but by the time the other CNA arrived his CNA already had him pretty well changed. Writer then asked nurse to give PRN medication (as necessary) as an intervention." E2, Director of Nurses, on 05/06/09 at 9:30 am in the beauty shop stated, "(R1) was very agitated and bothering other residents. The security guard came up to the unit." Surveyor asked E2 why the other Social Services or PRSC (Psychiatric Rehabilitative Services Coordinator) did not intervene in R1's behavior. E2 stated, "They have not been trained in Alzheimer/Dementia. There are social services workers and PRSC's on the other floors until 1:00 am. There are no social services or PRSC on the Alzheimer's/Dementia Unit after the Unit Coordinator (E4) leaves the facility at 5:53pm. Only the nurse can answer questions why the social service or the PRSC was not called. After	F9999		

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F9999	Continued From page 45	F9999		

hours, the security guard is to deal with residents on the Alzheimer/Dementia behavior. They haveCrisis Prevention Intervention (CPI) training. I cannot say they have been trained in a Alzheimer's or Dementia."

E2, Nurse, stated on 5/6/09 at 4:00 pm: "I called the security guard and the ADON (Assist. Director of Nurses) because he (R1) was trying to hit me. I did not call the social worker because there is no social worker for afternoon shift."

E4, Social Worker, on 05/06/09 at 10:30 am in the 4th floor Alzheimer Unit stated, "R1 was verbal abusive, repetitive movements, wandering and threatening to staff. R1 wanted to leave. He wanted to go home. He would ask for 'bus fare.'" Surveyor asked E4 if there is a social service on the unit after she leaves the facility to intervene with residents who have behavior problems. E4 stated, "No, the nurse and CNA are responsible for intervention of residents with behavior problems after I leave about 5:00 pm. There are no Social Workers or PRSC's trained on the Alzheimer/Dementia Unit. There is only 1 Nurse and 2 CNA's that have received dementia training on the unit:" E4 did not know if E10 (Security Guard) was trained for the Alzheimer/Dementia Unit.

E10, on 05/06/09 in the beauty shop stated, "I was called to come upstairs about 5:00 pm on the 4th floor Alzheimer Unit. The ADON was at the nurses station and the CNA was alone with R1 and a lady resident (R6). She accused him going into room taken personal items. R1 stated, 'I did not do it.' He was agitated because he was being accused. He got really mad and started walking toward the east hall exit door like he

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F9999	Continued From page 46 wanted to leave, saying, 'I am going home! I am going home! I am tired of this place.' I quickly intervened and said to R1 'you cannot leave.' He said 'who's going to stop me?' I said 'I was going to stop you from leaving.'" Surveyor asked E10, did you have any training Alzheimer/Dementia?" E10 stated, "I am not trained in the Alzheimer/Dementia. I am trained in CPI (Crisis Prevention Intervention) . CPI is where we prevented the residents form injuring staff, other residents and themselves." The care plan dated 04/20/09 stated, "Problems - R1 had been noted to attempt or state that he was going to elopement/ exit seeking familiar setting as evidenced by: (1) May/has verbalize wishes to leave or go home. (2) Looks persistently for a way to get out or get home. (3) Asks directions to the bus and ask for money/a bus pass. Ask staff for a ride. (4) Needs to go home to take care of his bills and check on his house/furniture. (5) Attempts to use the alarmed, fire exit doors. (6) Shows signs of increased agitation close to the sundown hours as evidenced by increased motor activity/increased efforts of leaving activity/exit seeking. The approaches in the care plan did not address R1's continued behaviors of wandering and abusiveness, and no new interventions were documented for the continued behavior of trying to elope. There was no evidence that the social worker had reassessed this resident for the continued wandering, elopement and abusive behaviors. There was no evidence R1 was referred to a psychiatrist for evaluation and treatment.	F9999		