STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E506	A. BUILDING _____ B. WING _____	06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW BEACH CARE CENTER	7325 SOUTH EXCHANGE CHICAGO, IL 60649

(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 406	Continued From page 31 - On 06/16/10 @ 2:30pm the group titled "Socialization D was observed for the entire time. There were 10 residents scheduled to attend, however none of the ten were present. During Daily Status, E1 (administrator) or E2 (asst. administrator) nor E3 (PRSD) could not provide an explanation for residents not attending these scheduled groups to address their maladaptive behaviors. As well, E3 could not provide evidence that residents were engaged in any therapeutic, structured programming on a consistent basis. All residents are qualified under Subpart S.	F 406		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 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	F9999		

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F9999	Continued From page 32 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 300.3240 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: A. Based on observations, interviews and record reviews, the facility failed to monitor and supervise a cognitively impaired resident (R20) out of a sample of 3 residents who are elopement risks in the total sample of 24 residents. These residents were assessed at risk for elopement and/or displaying behaviors of attempting to elope from the facility with monitoring and supervision. The incident of R20 eloping was the result of a systematic failure in which staff did not follow the facility's policy and procedures and did not implement/initiate the elopement policy. This failure resulted in a confused and disorganized resident (R20) eloping from the facility and traveling appropriately 25 miles from the facility, being gone for over 10 days, and facing potential hazards (crossing rail road tracks and busy intersections), without the supervision and monitoring his condition required for his severe mental illness. R20 was returned to the facility by ambulance. There is a potential that the other 8 residents identified at risk for elopement at the facility would be affected by this systems failure.	F9999		

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F9999	Continued From page 33 Findings include: a) R20 was interviewed several times on 6/17/2010. R20 was observed to be a confused resident with poor judgement, disorganized thinking and impulsive behavior. R20 was oriented to person and knew he was in a nursing home, but he was not alert to date or the name and location of the nursing home. When R20 was asked what happened when he left the facility on 5/08/2010, he reported the following: "I wanted to go and visit my mother. It was night. I got up and left thru the door in the dinning room." When asked about his mother, R20 told surveyors he did not know if his mother was dead or alive. R20 did not say where his mother lived. Surveyors asked R20 how he got out of the facility on 5/08/2010. R20 took surveyors to the dining room area and showed them how he pushed open the dining room door and exit out of the facility. R20 said he walked down the side walk, at the east side of the building. Then, he jumped the fence and went for a walk, however surveyor observed that this area was fenced in and had a gate which freely allowed excess to the street. This gated area was also observed not to be monitored by staff or monitoring device. The assistant administrator (E2) was interviewed on 6/16/2010 at 2:15 PM in his office. E2 told surveyor he conducted the investigation into R20's elopement on 5/08/2010. E2 stated that R20 was not allowed to go on a community pass because he is too confused. E2 said, "I did the investigation into R20's elopement. The DSW (direct service worker or certified nurses aide), E10 who came in at 7:00 AM, did her rounds. She did not see the resident. We learned later	F9999		

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F9999	Continued From page 34 the DSW (E9) working nights falsified the records. We belive he (R20) left sometime early in the morning, about 4:30 AM (on 5/08/2010). Later the resident was not found in the building. They searched the building and the community. Later, we found that the security guard (E8) on nights, heard the door alarm in the kitchen area go off. He (E8) went and looked but saw no one. ...He locked the door (to the kitchen area). He (E8) did not report the incident to anyone until I asked him about it. A head count was not done. A few days later, we received a phone call, he (R20) was at ...Hospital (a hospital located appropriately 25 miles from the facility).... He (R20) told us he walked around. He (R20) said he wanted to just take a walk, go to his mother's house, but he (R20) was too confused to find her house." Surveyor asked E2 how R20 got access at night to an area with easy access to exit doors. E2 said, "The door to the kitchen area was opened. Caused by human error." E2 indicated that someone just left the door dinning area unlocked. E8 (security guard) was interviewed in a conference room on the first floor on 6/17/2010 at 4:00 PM. E8 also accompanied surveyors to the dining room/kitchen area where R22 exited on 5/08/2010. E8 reported he was stationed in the front lobby area when the door alarmed. E8 said he went and checked the alarming door in the dining/kitchen area, but, he said he just quickly peeked out and did not see anyone. He showed surveyor how he quickly stuck his head out and closed the door. E8 told surveyors he did not search the grounds of the building because the weather conditions outside were bad, raining and windy. E8 also indicated he was the only security guard on duty. He said he was doing overtime	F9999		

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F9999	Continued From page 35 because the two security guards scheduled to work had called off work. Then, E8 said he went to the front of the building, looked outside, and saw no one. E8 told surveyors he did not tell anyone that the door had alarmed. E8 stated, "I did not know the elopement policy. I was working as a security guard for only a few months. I was originally hired as a receptionist. I was not inserviced on the elopement policy." E10 (DSW/CNA) was interviewed on 6/16/2010 by phone. E10 told surveyor, "I made my round at 7:30 AM and could not find R20. I told my supervisor and the DON (director of nursing). E10 reported that R20 was a "Red Dot" and not allowed on community passes. A search was not started when R20 eloped from the facility. The facility's staff were unaware that R20 was gone for approximately 3 hours because staff failed to follow policy and procedures. E28 (R20's PRSC) was interviewed on 6/18/2010 at 11:20 AM in a conference room on the first floor. E28 stated the following regarding R20's ability to travel in the community and his elopement : "Yes, I completed the Community Survive Skill Assessment of R20 (on 3/24/2010). When I asked him questions, he was unable to answer the time. He knew who he was, but not the location of the nursing home. I did not think he was coherent enough to go out into the community... I took him outside and I saw he was watching me, and maybe following what I was doing. I asked him questions about dangers in the community. He could not recognize dangers in the community. I asked him what possible risk could happen and he did not know. Possible risks like walking after dark, if a stranger	F9999		

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F9999	Continued From page 36 asked him to get into a car. He said he would not know what to do... The paramedics brought him back to the facility (on 5/18/2010). The paramedics said he was at ...Hospital (located approximately 25 miles from the facility). (When he came back from the elopement) His appearance was dishevel... He was confused. He had been off his medications for a length of time... without his medications, he can have bizarre behaviors (R20's care plan and psychiatric evaluation documented he has behaviors of smearing feces on the wall, masturbating in public and eating out of the trash). E35 (nurse) was interviewed on 6/16/2010 and 6/17/2010. E35 reported that she was R20's nurse. E35 said that R20 was not allowed to go on community passes. E35 described R20 as being too confused and not being able to think clearly enough to get back to the facility. E35 said, "R20 eloped. It happened one month ago... It was reported that he was on checks every 30 minutes. E35 said the DSW do the 30 minute checks." She stated they will document where the residents are at and what the residents are doing. R20's psychiatrist (Z1) was interviewed by phone on 6/17/2010 at 2:45 PM. Z1 stated, "He (referring to R20) was an elopement. I was not happy. They (he could not recall who reported R20's elopement to him) told me he slipped out a side door, and they found him a long way from the facility. They told me they were going to watch exits, pay attention to the red dot." Z1 told surveyor that without his medication, R20's mental condition gets worse.	F9999		

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F9999	Continued From page 37 Review of R20's Physician Order Sheet documented that R20 is a 28 year old male with diagnosis including: Bipolar Disorder and Schizoaffective Disorder. R20's physician ordered the following psychiatric medication to treat his medical condition: Clozapine 50 mg Three Times A Day and at Night Trazodone 100 mg at Night Haldol Decanoate 100 mg Every Two Weeks. A psychiatric evaluation completed on 5/19/2010, when R20 was sent to the hospital after the elopement, stated: "...referred here from...(the facility). The patient was very guarded delusional, paranoid, and suspicious. He had gone AWOL from the facility and was off his medication for at least several days. Past History: The patient has been hospitalized many times with a diagnosis of schizophrenia. paranoid type. When he does not get appropriate medications, his conditions worsens. He gets more agitated and upset. Identified Problems: 1. Paranoia 2. Noncompliance with needed medication 3. Increased delusions. Review of R20's Community Survive Skills Assessment dated 3/22/2010 documented the following: "No (1) The resident is sufficiently alert, oriented, coherent and knowledgeable allowing him/her to considered for independent outside pass privileges. No (2) The resident knows the facility address, location and how to contact the facility in an emergency.	F9999		

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F9999	Continued From page 38 No (6) The resident has knowledge of potentially dangerous situations, such as walking alone after dark, straying into an alley, accepting rides from strangers, ... Comments: During the interview with the resident, was unable to identify potential dangers in the community, unable to identify the address of the facility, and wasn't alert..." Review of R20's nursing notes was observed to have documentation of several episodes of R20 trying to leave the facility before 5/08/2010, and requiring the use of medication/chemical restraints and close monitoring/supervision. R20's nursing notes documented the following attempts: "4/15/2010 5:30 AM Resident tried to elope at 5:30 AM. Resident (R20)stated, "I just wanted to go home." Resident given Thorazine 2 ml (50 mg). IM... Resident placed on 1:1 monitoring. Will continue to monitor and check. 4/16/2010 at 6:30 AM ...Remains on 1:1... 4/28/2010 6:15 AM Resident escorted to nursing station due to elopement attempt. Resident stated, "I was just trying to get out the door. I would like to see my mom. PRN Thorazine given... Resident place on 1:1... 4/28/2010 Resident remains on 1:1 supervision... 4/29/2010 1:45 PM Resident maintain on 1:1 supervision... 4/30/2010 11:00 PM According to 24 hour report resident... taken off 1:1 monitoring, today resident was monitored every 15 minutes... 5/05/2010 11:00 PM Resident remains on 15 minute monitoring... 5/08/2010 8:30 AM Resident noted not in facility. Complete search of facility done."	F9999		

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F9999	Continued From page 39 Review of the R20's Close Observation Precaution Sheet documented that he was on 30 minutes checks while he was eloping from the facility on 5/08/2010. However, the documentation was falsified after 4:30 AM, because R20 had eloped and was not being monitored/supervised. Review of the hourly Safety Rounds Sheet documentation shows that R20 was AWOL or missing from the facility from 5/08/2010 at 7:00 AM until 5/18/2010 at 2:00 PM. This was for appropriately 10 days. Review of R20's care plan documented that R20 was at risk for Unauthorized Absence. 4/15/2010 was documented as the start date for this concern. The two interventions identified to address this care issue were: "Staff will call a code yellow for further assistance if the resident tries to leave the facility. Resident will be placed on observation checks to monitor his behavior" However, this plan of care was not implemented on 5/08/2010, when R20 left the facility. The DSW responsible for monitoring/supervising R20 failed to do observational checks on 5/08/2010. When the door alarmed on 5/08/2010, the security guard did not alert anyone or follow the facility's elopement policy and procedure so no one called a code yellow or did a head count of residents at risk. The plan of care and facility's system failed. Review of R20's care plan identified concerns, on 3/08/2010 that R20 had problems with "Cognitive Impairment and Poor Decision Making Skills." "The Goal is for this resident to increase his independence and make his needs known to	F9999		

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F9999	Continued From page 40 staff. Resident will find other ways to express his anxiety and not pace the hallways and wander around the facility. Target Date for this care issue was 6/08/2010. The interventions to reach this goal was for facility staff to "assist the resident with providing a structured schedule in order for resident to decrease his wondering around the building." Staff recognized R20's poor judgement and impaired cognition as indicating he needed a structured environment, or he just wanders. Review of the facility's elopement policy documented the following: "In an instance of elopement of a red dot resident, the PRSD will be called and the elopement and search practice will be implemented...." There was no evidence that the Administrator, the PRSD or anyone was informed "immediately" when R20 eloped on 5/08/2010. Even when staff became aware that R20 eloped, they did not immediately inform the administrator. Review of Protocol on Elopement revealed the following instructions for staff to follow: "Purpose: The idea behind the protocol is for staff to have a specific protocol should a resident succeed in eloping from the facility. Process: Once it has been determined that a resident may have or has eloped: staff should proceed with the following: 1.) Check the immediate building grounds (this should be done concurrently with the building sweep/head count). This includes checking both parking lots and the entire physical perimeter of the building. 2.) If evidence indicates that resident has eloped, a minimum of two staff should proceed in a vehicle and/or on foot in an attempt to locate	F9999		

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F9999	Continued From page 41 the resident. Staff conducting the outside search shall not be negatively impacting staffing levels/supervision within the facility. Staff will also go to all stops and businesses known to be frequented by the resident." This Protocol on Elopement was not followed by staff on 5/08/2010, when R20 eloped. A search was not done until approximately 3 hours after R20 was gone from the building. Review of E9's employee file documented that E9 was fired because she falsified documentation that R20 was monitored and present in the facility on 5/08/2010. Review of E9's employee file had multiple documentation instance of E9 falsifying records and not monitoring residents. The Employee Reports documented the following: "5/08/2010 Employee (E9) falsified documentation of round sheet. This is her second offense. Failed to make rounds." E9 was terminated. "5/13/2009... Employee falsified documentation . Resident was counted in house (facility) when he was discharged, another resident was not counted, another resident was admitted to facility at 2:30 PM 5/12/2009. and yet another male resident was counted in a female room. Employee suspended for 3 days." "12/02/2008... Employee (E9) witnessed/appears to be asleep in day room. Employee counseled that any further violations of work expectation prohibiting sleeping on the job will result in immediate termination. Consequence of action: One day suspension." "11/12/2008... (1) Noted round sheets to be done 1-2 hours ahead of time (verbal warning provided.) (2) Writer has talked to employee several times	F9999		