STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145946	A. BUILDING _____ B. WING _____	C 07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE AT HILLSIDE	**4600 NORTH FRONTAGE ROAD HILLSIDE, IL 60162**

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F 323	Continued From page 8 South exits, and 2nd floor musing station were upgraded to sound louder. Complete 5-21-10 8. Annunciator s were added to the East , West, and south hallways on both 1st and 2nd floors.	F 323		
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 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	F9999		

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F9999	Continued From page 9 or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on interviews and record reviews the facility failed to ensure the safety of 1 of 4 residents (R2) who was identified by the facility as having the potential and greatest risk for elopement. The facility failed to adequately supervise R2, a new admit, who left the facility without staff knowledge on 5-16-10 at approximately 11:00AM. The facility failed to accurately assess R2 who has dementia, and failed to ensure that R2 was wearing his electronic monitoring device. The facility assessed and identified R2 as being at risk for elopement but failed to monitor or supervise him . R2 is a dementia resident and is an unsafe wanderer. He was housed on a locked unit, and eloped from the facility for several hours. There is no indication whether R2 was wearing a electronic device, for which there was a written order by the director of nursing per family request.When located, R2 was not found wearing such a device. . Findings include: R2 is an 82 year old male who has a diagnosis of Alzheimer's and dementia according to his diagnosis sheet. He was assessed to be orientated times 2, not orientated to place. He was admitted to the facility on 5-13-10 and placed on the second floor. The second floor is a locked unit. It is also the dementia unit, and housed a total of 70 residents on 5-18-10. The	F9999		

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F9999	Continued From page 10	F9999		

doors are alarmed. On 5-18-10 E1 (Administrator) described the doors as having a 15 second delay before the alarm sounds, after being pushed.

Nursing notes state that on 5-16-10 around 11:05 AM staff was informed by the housekeeper on duty, that the west stairway door alarm was going off. "Writer went to the stairway to basement no resident or personnel noted." Staff on the 2nd floor and supervisors proceeded to look for R2, according to the nursing notes.

E1 stated during interview on 5-18-10 , that the facility was aware that R2 was told by family he would only be there a short period of time "3 days."

On 6-29-10 during interview, E8 (License Practical Nurse) who admitted R2 stated that on 5-14-10, she was informed by family that in order to get R2 to stay in the facility, he was told that he would only be in the facility 3 days. E8 also stated that during the initial assessment of R2, he was verbally repeating words and answers inappropriately and "not making a lot of sense." He was orientated to self but not place. E8 admitted during this interview that while completing the ELOPEMENT RISK ASSESSMENT for R2 on admission, she checked No, for the question #3. Question 3 reads: "Does resident demonstrate impaired judgement?" E8 later stated during interview on 6-29-10 that it should have been marked yes. E8 was also asked regarding the #5 question on the same inquiry, which states: "Does resident verbalized serious intent to leave the facility?" E8 marked Yes.

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F9999	Continued From page 11 Review of R2's care plan, showed that he was not believed to be at risk for elopement until the day he eloped on 5-16-10. E8 stated that on 5-14-10, she was informed that R2 was trying to leave the facility on the night shift. E8 wrote in the nursing notes and verified by interview that "he is not trying to leave the facility however R2 verbalized that he was ready to go home now." "He kept saying he was ready to leave," stated E8. E6 (housekeeping) stated during interview on 6-16-10 that on 5-16-10, the day R2 eloped, she heard an alarm go off. E6 further stated that earlier that day she observed R2 going from door to door pushing them trying to get out. "I redirected him." E10 (LPN) stated during interview on 6-16-10 that on the day R2 eloped, "I was down the hall, opposite of where he was. The housekeeper asked me had I seen him. I said no." E7 (Certified Nurses Aide) stated during interview on 6-16-10 that on the day R2 eloped around 10:55AM, she observed him in the dining room sitting at a table in his hat and coat looking out of the window prior to the elopement. E5 (Certified Nurses Aide) stated during interview on 6-23-10 that on the day R2 eloped, she did not hear an alarm. "I don't know if he was wearing a electronic device." E2 (Director of Nurses) stated during interview on 6-23-10 that she wrote the order for the electronic device on 5-13-10 at the family request. There is no record of this request being followed through	F9999		

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F9999	Continued From page 12 on. .	F9999		

E3 (Restorative Nurse) stated during interview on 6-23-10 that on the day R2 eloped that she did not hear an alarm. She further stated she was giving care to someone else, with the door closed, when someone informed her that R2 was missing. "I don't know if he had a electronic device on."

E4(LPN) stated during interview on 6-16-10, "I was down the hall when I was informed he(R2) was missing." She further stated that "I have worked with Dementia residents before and it is the first week that they try to leave." R2 left on the third day of admission.

R2 demonstrated the risk of elopement the day of admission,. An order was reviewed on the Physician Orders stating, "the resident may have an electronic monitoring device." When R2 was found he was not wearing a device.

E10 and E1 both stated that "The family tricked him into believing that he would only be here 3 days." He left on the 3rd day.

Review of R2 nursing notes on the day of his admission (5-13-10) reported that R2's behavior was anxious, evident by him "pacing back and forward that evening." Nursing notes further stated "will continue to monitor him."

On 5-14-10 at 11:30AM, nursing notes reported that R2 was "not trying to leave, will continue to monitor."

Review of the Elopement Risk Assessment form dated 5-13-10, date of R2's admission, #5 reads,

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F9999	Continued From page 13 "Does the resident verbalize serious intent to leave the facility?" The box was checked " yes." This indicates that staff identified R2 as a potential risk to leave the facility. On 5-16-10 at 10:55AM, nursing notes report that R2 was wandering in and out of other residents rooms . E6(housekeeping) stated during telephone interview that he (R2) was going from door to door shaking them to see if they will open. "Not long after, I heard an alarm go off and asked the staff where he was. Staff response was to look for him." E1 (Administrator) stated during interview, on 6-15-10, that he observed by camera that R2 was seen on camera going under the viaduct around 11:00AM, at the time staff was outside looking for him. E1 stated that "He was walking under the viaduct." The viaduct is located approximately 1 city block from the facility door. E7(CNA) stated that "I left him (R2) in the dining room sitting at a table around 11:00AM. He was being supervised by another CNA. He had on his hat and coat . I went to lunch." No Staff interviewed recalled hearing an alarm going off. However, according to E1 (Admistrator), R2 went down the second floor stairway. E1 also stated that he was not assessed as a risk. However, R2 has a diagnosis of dementia, and according to the initial Elopement Risk Assessment dated 5-13-10 R2 was assessed to "have verbalized serious intent to leave the facility. and having the physical ability to do so."	F9999		

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F9999	Continued From page 14 The facility also failed to identify R2 as having impaired judgment related to his diagnosis of Dementia and Alzheimer's Disease on this Elopement tool. This assessment information should have placed R2 at risk for elopement . On the third day of his admission, 5-16-10, R2 repeated the same behavior and elopement from the facility. E9 (LPN) was aware that the first week is when dementia residents are at the most risk to try to elope from the facility. Staff interviewed stated that no alarm was heard, however doctor's order stated that a electronic sounding device be placed on R2, 5-13-10. . Z1(Fire Dept) stated during interview on 5-18-10, via telephone, that when R2 was found he had on no electronic monitoring device. "He was found around 9:00PM. How did he get out of theire (facility), some (residents) have on a bracelet. He did not have on one." E1 also stated during interview on 5-18-10 that R2 was found near the 294 toll way interchange near Roosevelt road under the viaduct around 10:00PM. The police were called at 11:45am according the nursing notes. The facility measures to prevent the elopement were not effective. R2 was found some 10 hours later after being located at a busy interstate viaduct several miles from the facility by the fire department. R2's Community Survival skills assessment indicated on #5 of this tool that R2 was assessed to be knowledgeable of potentials dangers such as walking alone after dark. However R2 was found in the dark alone. The facility lacked a timely and accurate	F9999		

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F9999	Continued From page 15 assessment of R2, and failed to adequately supervise R2. (A)	F9999		