DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146065	A. BUILDING ______ B. WING ______	C **08/09/2011**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBINGTON REHAB & NURSING CTR	**31 WEST CENTRAL** **ROSELLE, IL 60172**

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F 000	INITIAL COMMENTS Incident Investigation of 07/13/11/IL53738 Extended Survey conducted.	F 000		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that 1 resident identified as high risk for wandering/elopement (R2) was provided with adequate supervision when he eloped from the facility and the alarm system failed to activate. This failure affected R2, with the potential to affect 2 other residents identified by the facility as wanderers, R1 and R3. On 07/13/11 R2 left the building without the alarm system being activated. He was hit and killed by a train a short time later while crossing nearby train tracks. The facility was unaware that R2 had eloped from the facility or why the alarm system failed to activate. This resulted in an Immediate Jeopardy. Although the Immediacy of the situation was removed on 07/19/11 at 4:15 PM the facility remains out of compliance at a level 2 until the	F 323		8/11/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 effectiveness of the facility's plan of correction can be evaluated. E1 (administrator) was notified by phone of the Immediate Jeopardy on 07/19/11 at 10:00 AM. Findings include: According to the medical record R2 was a 45 year old, ambulatory male who was admitted to the facility on 05/07/11. His diagnoses included Advanced AIDS, (Acquired Immune Deficiency Syndrome), Encephalopathy (swelling of the brain), Seizures and Brain Cancer with s/p (status post) resection in 2006, vp shunt, 2010, Cognitive Dysfunction and Substance Abuse. Upon admission R2 was assigned a room on the 2nd floor of the 2 story building. A nurses note of 05/08/11 at 6:50 am by E 5, RN (registered nurse night shift) documents that (after admission)R2 was oriented to the smoking rules of the facility, and the time breakfast is served. E 3, (1st floor nurse 3-11 shift) documents on 05/09/11 at 10:15pm, "needs re-direction at all times as resident is forgetful." E5's nurses end of shift note of 05/11/11 at 7:00 am documents the following: Resident wanted to smoke during shift." [night shift)] Nurse explained again regarding-smoking rules, regulation & schedule. Easily re-directed, however forgetful. At 4:20 am front door alarm went off. CNA immediately checked and saw res. [R2] smoking outside. Staff stayed and supervised res. Res was told not to go outside unsupervised. Nurse again explained regarding -	F 323		

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F 323	Continued From page 2	F 323		

smoking rules & regulation. Resident verbalized understanding but resident seemed to be forgetful.

E5's end of shift note of 05/14/11 at 7:05 am documents: Resident was seen wandering 3 times during shift. Re-directed several times but seemed forgetful. Needs constant cueing. Resident wants to smoke but was reminded about smoking rules & regulations.

E5's end of shift note of 05/17/11 at 7:30am documents : Res was seen wandering on 1st floor several times holding cigarette & lighter. Res was re-directed several times. Res got very mad. At 2:30 am alarm-door was heard by the patio. Staff checked & res attempted to open door to smoke. Res was re-directed per CNA."

On 05/19/11 according to Z1's (psychiatrist) evaluation progress note R2 was alert and oriented x 3 with some periods of forgetfulness. R2 told Z1 that he feels helpless, hopeless, no motivation, no interest and sometimes wishes to die. Z1 also noted that R2's judgement and insight were "fair." R2 was diagnosed with Major Depression and was prescribed the antidepressant Remeron, 15 mg. (milligrams) a day (at bedtime). Z1 also ordered psychotherapy for R2.

Z1 was interviewed by phone on 07/15/11 and stated that he comes to the facility once a week. When he last saw R2 during rounds he was out socializing with others per usual and did not show any signs of suicidal ideation. Z1 also stated that although R2 wished to be more independent, he was not showing signs of hurting

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F 323	Continued From page 3 himself. E5's end of shift note on 05/20/11 at 7:15 am documents: "At 2:30 am loud thud several times was heard. Nurses checked where the sound is coming from. Res. (R2) was seen outside patio. Nurse let him in and asked how did he get out & why? Res replied, "I went out for smoke." Nurse asked, "how did he know the code?" Res replied, I have a good memory." Res won't tell how he got the code." The note further documents that R2 was counseled about leaving the building unsupervised. E5 also documents that she informed E2(social worker) of the issue. E2 stated on 08/09/11 that she remembers counceling R2 regarding smoking rules and that the code to the patio was probably changed. E2 also stated that there were no changes to R2's careplan after the incident and R2 was not restricted, placed on checks or monitored more closely. 5/22/11, 6:55 am E5 documents that earlier in the shift a smell of cigarette smoke was noted in the hallway by R2's room. R2 denies smoking in his room. E5 told CNA to supervise R2 closely regarding smoking in his room. At 7 am R2 is again observed on his way out the patio door. E1(administrator) stated on 08/09/11that E5 went over the smoking policy again with R2 after the incident and he was re-directed when he tried to go out to the patio at 7AM. No other interventions were initiated at this time to supervise R2 more closely. 05/26/11 1:00 pm nurses note by E6, LPN	F 323		

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(licensed practical nurse) documents that R2 left the facility without permission. After staff searched the building R2 was seen coming from the gas station (which is located on the other side of 2 sets of train tracks.) At this point the facility intervened and the use of a wandering device was implemented.

Review of nursing progress notes documents that there were no incidents of attempted elopement throughout the month of June, 2011. However on 06/28/11 R2 was seen by the infectious disease physician at 10 am. At 11:30 am the doctor's office called stating that R2 was suicidal and he was sent to the hospital. R2 returned to the facility at 4:30 pm.
E1stated that R2 was not monitored more closely after his return because his doctor at the clinic misunderstood R2 and that he wasn't actually suicidal at all.

No further documentation was found in the record that the facility implemented any further interventions after R2 returned to the facility from the hospital.
The only reference to the incident in the record after this occurred was a note by E8 (LPN) on 06/29/11 which stated, "Denies any suicidal plans."

On 07/0711 R2's Elopement Risk Assessment form documented that his wandering device was discontinued on 07/07/11. E2 stated on 07/15/11 that R2's "out on pass privileges" were reinstated after R2 was re-assessed and noted to be following facility policies.

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F 323	Continued From page 5 On 07/11/11 a 10:30 PM nurses note by E3 documents that R2 left the building sometime before 7:50 PM. without signing out. He was seen by the receptionist at approximately 8:15 pm crossing the street heading towards the gas station. (across the railroad tracks). At approximately 9:55 pm R2 returned to the facility through the patio door. R2 was counceled by E2 after he returned and he was told he may have his pass revoked and he could not go out on his own anymore. The physician was notified and the wandering device was re-applied on 07/12/11. R2's order was changed to "can only go out with family". E3's (nurse on duty) note in the record dated 07/13/11 documents that R2 was given his medication at approximately 9 PM. After that he was observed by E3 leaving his room. During rounds (approximately 20 minutes later), R2 was not in his room or the patio. All staff were instructed to search the facility. At approximately 9:30 PM second floor nurse, E4 was asked to look for R2 at the gas station, (which is located across the street beyond two sets of railroad tracks). E4 returned a short time later stating that he could not get to the gas station because there was an accident. At 10:15 PM a police officer entered the building and asked if anyone was missing from the facility. The officer also stated that someone had been hit by a train. E1 (administrator) stated on 07/14/11 that she was called to the facility after the incident occurred. E1 was asked to go to the scene of the accident. E1 was allowed to get close enough to the scene to identify the body. R2's foot was visible and he was identified by E1 because his	F 323		

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F 323	Continued From page 6 wandering device was still attached to his ankle. E1 also stated that there were no problems found with the facility's alarm system and their investigation was unable to determine how R2 was able to leave the building without triggering the alarm. R2's wandering device remained on his ankle and could not be tested by the facility. On 07/14/11 surveyor accompanied by E2 (social services director) checked all alarmed doors in the facility. The 2 remaining residents who wear wandering devices were assessed for the proper placement and function of their devices. Direct care staff were observed and interviewed as the alarms were activated. Staff acted quickly to disable the alarms after coming to the area. E2 explained that all of the alarms require a code to be input in order to stop the alarm from ringing after it is triggered. No problems were found with any of the alarms on 07/14/11. E2 stated that she personally tested R2's wandering device on 07/12/11 prior to attaching it to his ankle. E2's social service notes also reflect that the alarm was checked prior to it's application. E3 was interviewed on 07/15/11 and stated that she did not notice anything unusual with R2 on 07/13/11 and did not hear any alarms go off at the time of R2's elopement from the facility. E9, CNA was interviewed on 07/15/11 and stated that at the time of the elopement of 07/13/11 she was in a resident's room doing care and did not hear any alarms go off. E10, CNA was interviewed by phone on 08/14/11 and stated that she did not hear any alarms go off on 07/13/11 and if an alarm does go off you have to punch in the code to shut it off. The Immediate Jeopardy was determined to	F 323		

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have begun on 07/13/11 shortly after 9:00 PM when staff became aware that R2 was not in the building, they did not know where he was, and the alarm did not trigger to indicate that he had left.

It was confirmed through interview, observation, and record review that the facility took the following actions to remove the Immediate Jeopardy:

1. The facility has reviewed and revised it's wandering device policies and procedures. Responsible for implementation : Director of Nursing

2. The facility will test all door alarms daily and keep a log. To be implemented by Maintenance Dept.

3. The wandering device system is being tested for functionality daily and a log will be kept. Responsible party- Maintenance

4. Visual checks for placement of wandering devices on residents will be done daily and a log will be kept. Charge nurse will be responsible.

5. Residents who wear wandering devices will not be allowed to go out on the patio without one on one supervision. charge nurse, direct care staff.

6. Residents' assessments will be reviewed to assure that all residents who need wandering devices will have them. Careplans will be updated to reflect assessments as appropriate.

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F 323	Continued From page 8 Careplan co-ordinator or social services. 7. On or before 07/19/11, inservices will be held with appropriate facility staff. Administrator or designee will conduct the inservices. Staff including: Supervisors, dietary, maintenance, housekeeping as well as direct care staff. The inservices will include: a) a review of the requirement that the facility reasonably assures that residents' environment remains as accident free as possible. b) a review of the allegations c) a review of the facility's revised policies and procedures for wandering devices. Corrective actions will be monitored by charge nurses for compliance through daily rounds and review of logs. Any trends in noncompliance and/or need for additional inservices will be addressed. The Director of Nursing will monitor for overall compliance through her supervision of staff. The facility's abatement plan was reviewed and accepted on 07/19/11 at 4:00 PM.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210d)6) 300.3100d)2)	F9999		

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F9999	Continued From page 9 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. 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. d) Pursuant to subsection (a), 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	F9999		

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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 300.3100 General Building Requirements

d) Doors and Windows
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.

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 requirements are not met as evidenced by:

Based on observation, record review and interview the facility failed to ensure that 1 resident identified as high risk for wandering/elopement (R2) was provided with adequate supervision when he eloped from the facility and the alarm system failed to activate.

This failure affected R2, with the potential to affect 2 other residents identified by the facility as wanderers, R1 and R3. On 07/13/11 R2 left the building without the alarm system being activated. He was hit and killed by a train a short time later while crossing nearby train tracks.

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F9999	Continued From page 11 The facility was unaware that R2 had eloped from the facility or why the alarm system failed to activate. Findings include: According to the medical record R2 was a 45 year old, ambulatory male who was admitted to the facility on 05/07/11. His diagnoses included Advanced AIDS, (Acquired Immune Deficiency Syndrome), Encephalopathy (swelling of the brain), Seizures and Brain Cancer with s/p (status post) resection in 2006, vp shunt, 2010, Cognitive Dysfunction and Substance Abuse. Upon admission R2 was assigned a room on the 2nd floor of the 2 story building. A nurses note of 05/08/11 at 6:50 am by E5, RN (registered nurse night shift) documents that (after admission) R2 was oriented to the smoking rules of the facility, and the time breakfast is served. E3 (1st floor nurse 3-11 shift) documents on 05/09/11 at 10:15pm, "needs re-direction at all times as resident is forgetful." E5's nurses end of shift note of 05/11/11 at 7:00 am documents the following: "Resident wanted to smoke during shift. [night shift)] Nurse explained again regarding-smoking rules, regulation & schedule. Easily re-directed, however forgetful. At 4:20 am front door alarm went off. CNA immediately checked and saw res. [R2] smoking outside. Staff stayed and supervised res. Res was told not to go outside unsupervised. Nurse again explained regarding -	F9999		

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F9999	Continued From page 12 smoking rules & regulation. Resident verbalized understanding but resident seemed to be forgetful." E5's end of shift note of 05/14/11 at 7:05 am documents: "Resident was seen wandering 3 times during shift. Re-directed several times but seemed forgetful. Needs constant cueing. Resident wants to smoke but was reminded about smoking rules & regulations." E5's end of shift note of 05/17/11 at 7:30am documents: "Res was seen wandering on 1st floor several times holding cigarette & lighter. Res was re-directed several times. Res got very mad. At 2:30 am alarm-door was heard by the patio. Staff checked & res attempted to open door to smoke. Res was re-directed per CNA." On 05/19/11, according to Z1's (psychiatrist) evaluation progress note, R2 was alert and oriented x 3 with some periods of forgetfulness. R2 told Z1 that he feels helpless, hopeless, no motivation, no interest and sometimes wishes to die. Z1 also noted that R2's judgement and insight were "fair." R2 was diagnosed with Major Depression and was prescribed the antidepressant Remeron,15 mg. (milligrams) a day (at bedtime). Z1 also ordered psychotherapy for R2. Z1 was interviewed by phone on 07/15/11 and stated that he comes to the facility once a week. When he last saw R2 during rounds he was out socializing with others per usual and did not show any signs of suicidal ideation. Z1 also stated that although R2 wished to be more independent, he was not showing signs of hurting	F9999		

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himself.

E5's end of shift note on 05/20/11 at 7:15 am documents: "At 2:30 am loud thud several times was heard. Nurses checked where the sound is coming from. Res. (R2) was seen outside patio. Nurse let him in and asked how did he get out & why? Res replied, 'I went out for smoke.' Nurse asked, 'how did he know the code?' Res replied, I have a good memory." Res won't tell how he got the code."

The note further documents that R2 was counseled about leaving the building unsupervised. E5 also documented that she informed E2 (social worker) of the issue. E2 stated on 08/09/11 that she remembered counceling R2 regarding smoking rules and that the code to the patio was probably changed. E2 also stated that there were no changes to R2's careplan after the incident and R2 was not restricted, placed on checks or monitored more closely.

5/22/11, 6:55 am E5 documents that earlier in the shift a smell of cigarette smoke was noted in the hallway by R2's room. R2 denies smoking in his room. E5 told CNA to supervise R2 closely regarding smoking in his room. At 7:00 am R2 was again observed on his way out the patio door. E1 (administrator) stated on 08/09/11that E5 went over the smoking policy again with R2 after the incident and he was re-directed when he tried to go out to the patio at 7:00 am. No other interventions were initiated at this time to supervise R2 more closely.

05/26/11 1:00 pm nurses note by E6, LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146065	A. BUILDING ______ B. WING ______	C 08/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBINGTON REHAB & NURSING CTR	31 WEST CENTRAL ROSELLE, IL 60172

(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
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(licensed practical nurse) documents that R2 left the facility without permission. After staff searched the building R2 was seen coming from the gas station (which is located on the other side of 2 sets of train tracks.) At this point the facility intervened and the use of a wandering device was implemented.

Nursing progress notes document that there were no incidents of attempted elopement throughout the month of June, 2011. However on 06/28/11, R2 was seen by the infectious disease physician at 10:00 am. At 11:30 am the doctor's office called stating that R2 was suicidal and he was sent to the hospital. R2 returned to the facility at 4:30 pm. E1stated that R2 was not monitored more closely after his return because his doctor at the clinic misunderstood R2 and that he was not actually suicidal at all.

No further documentation was found in the record that the facility implemented any further interventions after R2 returned to the facility from the hospital. The only reference to the incident in the record after this occurred was a note by E8 (LPN) on 06/29/11 which stated, "Denies any suicidal plans."

On 07/0711 R2's Elopement Risk Assessment form documented that his wandering device was discontinued on 07/07/11. E2 stated on 07/15/11 that R2's "out on pass privileges" were reinstated after R2 was re-assessed and noted to be following facility policies.

On 07/11/11 a 10:30 pm nurses note by E3 documents that R2 left the building sometime before 7:50 pm. without signing out. He was seen

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F9999	Continued From page 15 by the receptionist at approximately 8:15 pm crossing the street heading towards the gas station (across the railroad tracks). At approximately 9:55 pm R2 returned to the facility through the patio door. R2 was counseled by E2 after he returned and he was told he may have his pass revoked and he could not go out on his own anymore. The physician was notified and the wandering device was re-applied on 07/12/11. R2's order was changed to "can only go out with family." E3's (nurse on duty) note in the record dated 07/13/11 documents that R2 was given his medication at approximately 9:00 pm. After that he was observed by E3 leaving his room. During rounds (approximately 20 minutes later), R2 was not in his room or the patio. All staff were instructed to search the facility. At approximately 9:30 pm second floor nurse, E4 was asked to look for R2 at the gas station (which is located across the street beyond two sets of railroad tracks). E4 returned a short time later stating that he could not get to the gas station because there was an accident. At 10:15 pm a police officer entered the building and asked if anyone was missing from the facility. The officer also stated that someone had been hit by a train. E1 (administrator) stated on 07/14/11 that she was called to the facility after the incident occurred. E1 was asked to go to the scene of the accident. E1 was allowed to get close enough to the scene to identify the body. R2's foot was visible and he was identified by E1 because his wandering device was still attached to his ankle. E1 also stated that there were no problems found	F9999		

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with the facility's alarm system and their investigation was unable to determine how R2 was able to leave the building without triggering the alarm. R2's wandering device remained on his ankle and could not be tested by the facility.

On 07/14/11 surveyor, accompanied by E2 (social services director), checked all alarmed doors in the facility. The two remaining residents who wear wandering devices were assessed for the proper placement and function of their devices. Direct care staff were observed and interviewed as the alarms were activated. Staff acted quickly to disable the alarms after coming to the area. E2 explained that all of the alarms require a code to be input in order to stop the alarm from ringing after it is triggered. No problems were found with any of the alarms on 07/14/11. E2 stated that she personally tested R2's wandering device on 07/12/11 prior to attaching it to his ankle. E2's social service notes also reflect that the alarm was checked prior to its application.

E3 was interviewed on 07/15/11 and stated that she did not notice anything unusual with R2 on 07/13/11 and did not hear any alarms go off at the time of R2's elopement from the facility.

E9, CNA was interviewed on 07/15/11 and stated that at the time of the elopement of 07/13/11 she was in a resident's room doing care and did not hear any alarms go off.

E10, CNA was interviewed by phone on 08/14/11 and stated that she did not hear any alarms go off on 07/13/11, and if an alarm does go off you have to punch in the code to shut it off.

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