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 02/28/2012

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 7 indicates the following: the facility is to act in a proactive manner to identify and assess those residents at risk for falls/elopements and plan for preventive strategies and facilitate as safe an environment as possible and that all high risk elopement residents are to be monitored every hour. Review of the facility elopement policy does not indicate that the windows are to be checked hourly or any mention of window security.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care	F9999		

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F9999	Continued From page 8 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 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. These requirements are NOT MET as evidenced by: Based on interview and record review, the facility failed to implement elopement risk prevention involving 1 of 3 residents (R4) reviewed for accidents/supervision of a sample of 10 residents. This failure resulted in R4 exiting from the window resulting in a fall of 14 feet and sustaining a fractured right wrist. Findings include: R4 is a 76 year old admitted to the facility on 6-6-11 with medical diagnosis which includes: Schizophrenia, Parkinson ' s disease and Dementia. At the time of admission, R4 was determined to be at risk for falls and elopement.	F9999		

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F9999	Continued From page 9	F9999		

R4 was placed on the dementia unit which is a secured unit.
Review of nurses notes indicates the following:
1. 10-18-11 8:00 AM-resident attempted to elope times two. Elopement guard wrist device not present. Notified DON (Director of Nursing), unit manager and nurse supervisor. All parties made aware. Endorse to 3-11 shift to monitor.
2. 10-19-11 8:00 AM-up ambulating the hall. Will continue to monitor.
3. 10-23-11 3:55 PM-resident attempted to get on elevator to go down stairs. Stated she wanted to ride the elevator and go up and down for a ride. She was redirected and went back to her room. Staff will continue to monitor.
4. 10-23-11 10:45 PM-said writer(E7) was informed by the CNA(Certified Nurses Aide) that one of the employee's husband came to the door and stated that R4 had jumped out the window and once outside, found R4 lying in the bushes. R4 was alert and oriented, no complaint of pain or in distress. R4 stated she was trying to go to the store. 911 was called. R4 was taken to the local hospital and was diagnosed with a right wrist fracture. Family and physician were both modified.
careplan review indicated that R4 was at risk for falls and elopement. R4 never previously attempted to elope from the window.
R4 resided in room 219. R4's fall was 14 feet from window to ground (landed in bushes). The window that R4 exited from had two safety features: flip lock and a screw that was supposed to be drilled into the lower frame to prevent the window from opening wider than an estimated 8 inches. The screw in the window frame is a safety intervention on the dementia unit used to reduce the risk of possible elopement by way of the

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F9999	Continued From page 10	F9999		

window. the window opens from left to right which may be at 3 feet in the total open position.
R4 was able to climb up on a chair, open the window (was found to be open at 18 inches), push out the screen and jump out from the window, landing in the bushes. there is no evidence to indicate if perhaps another resident opened the window for R4.
Review of the local police department report dated 10-23-11 at 10:43 PM indicates the following: the window is supposed to have a special screw to prevent the window from opening too far. The screw for R4's window was missing. It is unknown if R4 removed it or if it was previously missing. R4 is a petite woman and did not need to open the window very much to fit through.
Evidence indicates that at the time of R4's exit from the window, the screw was not secured to prevent the window from opening 8 inches.
Review of a monitoring form dated 10-23-11 indicates that R4 was visually monitored every hour but does not include checking the window for security.
Interview with E6 (Licensed Practical Nurse) on 2-23-12 at 12:30 PM stated that all residents at high risk for elopement are monitored every hour.
Interview with E7(Dementia Unit Coordinator) on 2-23-12 at 11:30 AM stated that monitoring of the high risk elopement residents does not include checking the security of the windows, only a visual of the resident and that R4 was monitored hourly on 10-23-11.
Interview with E5 (Maintenance Director) on 2-23-12 at 12:30 PM stated that the screws are secured into the frame of the window on the dementia unit to prevent the windows from opening no more than 8 inches. E5 also stated

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F9999	Continued From page 11 that the screws can only be removed by a screw driver. E5 also stated that in October of 2011, the checking of the windows was only twice weekly. E5 also stated that the window was discovered to have been opened at about 18 inches on the time after R4's exit from the window. Interview with E1(Administrator) on 2-23-12 at 3:00 PM stated that he was not the administrator at the time of the incident, but the maintenance department duties now include documenting all window checks for proper locking capabilities including screw placement. Policy review regarding falls and elopement indicates the following: the facility is to act in a proactive manner to identify and assess those residents at risk for falls/elopements and plan for preventive strategies and facilitate as safe an environment as possible and that all high risk elopement residents are to be monitored every hour. Review of the facility elopement policy does not indicate that the windows are to be checked hourly or any mention of window security. (B)	F9999		