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AURORA REHAB & LIVING CENTER	**1601 NORTH FARNSWORTH AVENUE AURORA, IL 60505**

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F 323	Continued From page 34 effectiveness. Any new incidents that occur will be reviewed to ensure the policy was followed. Any discrepancies noted will be identified and new interventions will be implemented as determined by the QA committee. - The Medical Director has reviewed facility's policy and procedures related to this event. The facility sought the Medical Director's consultation for this plan of "abatement". The Medical Director will assume the care for any patient whose primary care physician does not respond in the event of an emergency. The Medical Director will continue to visit at least monthly to provide support, guidance and education to ensure the staff are properly trained to provide appropriate care to residents. The Administrator and DON will be responsible for compliance.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.1210d)3)6) 300.3240a) 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.	F9999		

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F9999	Continued From page 35 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: 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 need for further medical evaluation and treatment shall be made by nursing staff and recorded 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. 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 regulations are not met as evidenced by the following: Based on observation, interviews and record review facility failed to: 1) Supervise and ensure the safety of 1 of 1 sampled residents (R2) with an acute mental status change on 12/31/11. R2's mental status progressively declined over a 7 hour period with increasing agitation, confusion, repetitive disrobing and un-safe repetitive independent ambulation. R2 also wandered out of his room and into other residents' rooms, upsetting the other residents. Over the course of this 7 hour	F9999		

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time frame the night shift staff had increasing difficulty re-directing R2. This lead to R2 becoming physically aggressive with a staff member during re-direction that resulted in physical injury to that staff member. While R2 was exhibiting agitated, aggressive and destructive behaviors, the nursing staff failed to monitor, supervise and obtain timely medical evaluation and treatment. When R2 was observed exhibiting violent aggressive behaviors of banging objects against the wall with such strength as to dent the walls, the nursing staff closed the resident's door and left him un-supervised in his room. When the staff returned to the nursing station R2 climbed out of his unsecured bedroom window.

2) Secure "70%" of resident room windows on the 500 unit (currently occupied by 26 residents), to prevent the windows from opening more than 6 inches, as per facility protocol.

3) Complete a thorough and accurate investigation for R2 who eloped from the facility.

These failures resulted in R2 eloping from the facility through an unsecured window and being found naked, lying on the ground, with multiple bleeding abrasions all over his body. R2 was log rolling erratically back and forth in the northbound lanes of a 4 lane heavily traveled roadway. This roadway is located approximately one city block south of Interstate 88 entrance ramps. In addition, staff witnessed multiple passersby using their cell phones to record R2 while he was lying in the street. The outside air temperature on the morning of 12/31/11 in Aurora, Illinois was 25 degrees Farenheit, (excluding the windchill

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F9999	Continued From page 37 factor). Findings Include: R2 was admitted to the facility on 12/28/11 at 4:30 PM from an acute care hospital with diagnoses including : S/P (Status Post) Subdural Hematoma, (CVA) Cerebral Vascular Accident, Hypertension, Seizure disorder, Change in Mental Status and history of falls. R2 was assessed on admission as 5 foot 11 inches tall and 310 pounds. The Facility's Incident Investigation Reports and Nurses notes included the following: On 12/31/11 R2 experienced an acute mental change at approximately 4:30 AM. The resident was frequently monitored and no incidents noted until approximately 7:45 AM when the resident was exhibiting new behaviors. The nurse immediately went to notify the physician (MD) and obtain orders to send R2 out to the emergency room (ER) for an evaluation. Upon returning to the room within three minutes, the nurse noted R2 was not in the room and the window was open. Staff found R2 in front of the facility on the ground. R2 was assessed and noted with abrasions to the face and legs. No other injuries noted. Paramedics on site and assisted R2 to the ambulance, then to the ER. R2 was admitted to the hospital for Acute Mental status changes. Per interview with hospital staff, R2 experienced acute mental status changes with hallucinations that could have been related to his status post Subdural Hematoma or an adverse medication reaction.	F9999		

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R2's medical record included:

- 12/28/11 Hospital discharge records noted R2 was experiencing altered mental status for three days prior to admission to the acute care hospital after sustaining a fall with a head injury. R2 developed frontal lobe pain and was taking anti-coagulant medication at home. (R2 was admitted to the hospital 12/26/11).

- 12/29/11 psychological evaluation includes the following: R2 admits to having visual hallucinations (seeing people), confusion and altered mental status. Alert and oriented times one, cooperative, decreased judgement, decreased insight and short term memory problems. Diagnosed with Dementia with behavioral disturbances, rule out dementia secondary to medical / multiple etiology.

This psychological evaluation was prompted due to R2's exhibited behavior changes.

Nurses progress notes:

- 12/28/11 alert and oriented times 3 (time, place and person), mental status appears normal, left sided weakness from a prior CVA, no loss of range of motion (ROM), ambulates to bathroom and has slight tremors at times.

- 12/29/11 5:30 PM R2 is confused and oriented times one. Requires 2 assist with transfers to wheel chair.

- 12/30/11 5:51 PM Confused with spouse.

- 12/30/11 10:02 PM Becoming upset at his wife,

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accusing her of having an affair and playing games with him. Wife denies any truth to R2's statements. R2 was calmed down but required a lot of re-focusing.

- 12/31/11 11:36 AM R2 climbed out his bedroom window at 8:0 AM. R2's mental status was normal then increased agitation and confusion. R2 was in his room one moment beating on the wall with a planter, then climbed outside through the window.

- 12/31/11 (note: appears to be a late entry) 11:49 AM At 11:00 PM R2 in bed sleeping with no complaints.
1:00 AM R2 noted in his bathroom, he had ambulated there himself, escorted resident back to bed.
4:05 AM R2 found in another resident room bumping into wheelchair and furniture. R2 escorted back to his room. A short time later R2 kept getting out of bed and attempted to ambulate without assist, staggering with obvious un-steady gait and requiring physical assist to get back to bed. After E4 left R2's room R2 started exhibiting aggressive behaviors toward a staff member (E6 nurse aide), grabbing E6's arm and refusing to let her go. E4 had to help free E6 from R2's grasp and E6 sustained bruises from this incident. E4 called Z2 (R2's doctor), and obtained orders for Haldol 5 mg injection to be administered now.
"7:45 AM resident was noted in his room with the planter banging it on the wall as in trying to break through it, resident was not able to be redirected by writer so another emergency call was placed to Z2 for permission to send to emergency room due to increased agitation and possible danger to staff and residents in the general area. After Z2

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gave order to send R2 to the hospital, writer went back to resident's room not more than 3 minutes had past, when it was discovered that resident got out of his room via window."

E4 ran outside to Farnsworth street in case R2 made it that far and R2 was spotted on the ground in the nude, rolling around in the middle lane of Farnsworth street log rolling himself in the path of oncoming traffic. E4 ran into the street waving his hands up in the air to stop the flow of traffic and keep R2 from being run over. R2 was removed from the street after covering his body with E4's coat with much difficultly due to R2 not helping to stand up on his feet, with assistance of multiple staff. 911 arrived once R2 was removed from the street and to the safety of the grass area. R2 was immediately transported to the hospital.

R2's medical record included only one Elopement Risk assessment dated 01/04/12, (after this incident). During 02/08/12 interview, E1 said R2 was not assessed for Elopement Risk on initial admission because he was just admitted for rehab therapy on the short term rehab unit (500 wing). R2's 01/04/12 Elopement Risk care plan includes that resident previously eloped from facility and had a catastrophic reaction to psychotropic medication (Haldol).

During a 02/08/12 9:00 AM interview, E4 said on 12/23/11 at about 1:00 AM R2 was found up in bathroom, unassisted and with unsteady gait. E4 assisted R2 back to bed and had a conversation with resident about his past occupation. R2 was alert, cooperative and calm. Then at 4:00 AM R2 was found in another resident's room, "messing"

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with peers wheelchair and touching the walls. R2 was initially resistant to leaving this other resident's room which caused this other resident to become upset. R2 was unsteady walking and leaned heavily against E4's body while ambulating to a wheelchair, acting as if he could not walk. R2 was alert and oriented and communicative at this time. Shortly after returning R2 to his bed, while in the nursing station, E4 heard E6 (R2's nurse aide), calling out "Let me go," from down the hall. E4 witnessed R2 firmly grasping E6's arm and E6 was saying, "Don't squeeze so hard." E4 ran to assist E6 and when R2 saw E4, R2 started acting like he could not stand without physical assist. E4 said that E6 was assisting R2 to bed when he grabbed her arm. E6 sustained bruises to the arm from this incident. E6 stayed with R2 while E4 went back to the nursing station to call MD. The MD ordered an injection of Haldol be given. R2 said he wanted the shot. R2 remained in bed after the Haldol was administered until about 7:45 AM. At 7:45 AM E4 heard a loud banging noise, like construction was going on, coming from R2's room. Upon inspection of the noise, R2 was observed grasping a planter with two hands and banging it against the wall causing dents. E4 said that he was a little scared that R2 might hit him with the planter but was able to get the planter away from R2 and assist him back to bed in a sitting position. R2 would not verbally respond when spoken to and just starred at E4. E4 left R2 alone in his room to return to the nursing station and call R2's MD. E4 said that E6 was working with another resident at the time R2 was banging the planter on the wall and he was not sure if E6 even heard it. The resident in the room next to R2's room was upset and yelling about all the noise

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that R2 was making. Upon E4's return to R2's room, E4 pushed the door open, felt a cold wind and noticed R2 was gone. E4 did not think R2 got out the window because the resident was so large and had an un-steady gait, but E4 did not see R2 leave his room or walk past the nursing station. E4 left R2's room and proceeded to the exit door yelling for co-workers to assist in finding R2. E7 (nurse aide) followed E4 outside the facility, across the parking lot toward the street. R2 was observed naked, log rolling back and forth on the ground into traffic in the northbound lanes of Farnsworth street. E4 ran into the street, holding his arms up in the air to halt traffic and then placed his jacket on top of R2 because people were using their cell phones to take pictures of him. R2 had scrapes and abrasions all over his body that were bleeding. E4 said that he thinks that if he and E7 had not gotten to R2 when they did, R2 could have been hit by one of the cars that were trying to go around stopped vehicles. In addition, E4 said throughout that night R2 would frequently remove all his clothes and needed frequent redirection to reapply his gown.

During a 02/08/12 12:00 PM interview, E7 said that she was R2's 12/31/11 6 AM-2 PM assigned nurse aide. E7 said on 12/31/11 upon arrival, when she received her assignment for that shift, E7 was notified R2 was agitated and his door was closed. E4 told E7 to not go in R2's room because of him being agitated. E7 said she did not go into R2's room at all that shift. E7 said that around 8:00 AM or a little after, while passing breakfast trays, E4 asked her to follow him outside. E7 observed R2 rolling around back and forth, on the ground in the northbound lane of the street. There was oncoming northbound traffic E7

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said she did not hear R2 banging on the walls and did not know anything was going on with the resident until E4 asked her to go outside with him. E7 also said it was not until later that shift, after R2 was transported to the hospital, that she was notified R2 had a confrontation with the night shift nurse aide (E6). E7 said she had worked with R2 on prior shifts and he never exhibited any behavior problems before 12/31/11.

During a 02/08/12 12:20 PM telephone interview, E6 said she was R2's assigned nurse aide 12/30/11 11 PM - 12/31/11 7:00 AM shift. E6 also said that on 12/31/11 R2 was acting different from the prior two nights. R2 usually is quiet, sleeping or watching his television at night without any behaviors. On 12/31/11 at approximately 5:00 AM, E6 saw R2 walking at a rapid pace in the hall with an un-steady gait. E6 called for E4 to assist getting R2 back to bed. R2 just sat on the bed so E4 told E5 to keep an eye on him. E6 was in the hallway and another resident called her to his room for assistance, so E6 went. When E6 returned to the hallway E6 saw R2 quickly exiting his room again. R2 grabbed E6's arm with one hand and attempted to hit E6 with the other hand. R2 was trying to push E6 out of the way as he tried to exit his room. E6 yelled for E4 to come help her, which he did. E4 told R2 to stop and go back to his bed. R2 is a big man. E4 returned to the nurses station and E6 stayed in the hall in front of another resident's room to watch for R2 leaving his room. E6 stayed out of view of R2. E6 said she did hear R2 banging on the walls and getting agitated and saw E4 come to R2's room. E6 said that she left the facility to go home at 7:30 AM, prior to his elopement incident.

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During a 02/08/12 2:45 PM telephone interview, E9 (nurse) said she was R2's 12/31/11, (7 AM-3 PM) assigned nurse. On 12/31/11 during morning report, E4 told her that R2 was going in and out of other residents' rooms during the night. R2 required a medication to calm him down. During this change of shift report E4 and E9 heard a banging sound coming from R2's room. E4 and E9 went to check on the noise and entered R2's room. R2 was observed to be very confused and banging a fake planter against the wall. E4 and E9 both left R2 alone in his room and closed his bedroom door. E9 said the nurses went back to the nursing station to call R2's MD. 3-4 minutes later E4 returned to R2's room and found the resident missing.

R2's 12/31/11 Hospital Record includes:
R2 was hospitalized 12/31/11 through 01/04/12 with diagnosis to include Altered Mental Status, History of Seizure disorder, History of Sub-dural Hematoma and History of Cerebral Vascular Accident.
The 12/31/11 History and Physical included that R2 developed extreme agitation, broke glass window, ran out and was found in the street without any clothes and with bruises all over his body.
R2's 01/01/12 Neurological consult report included that "etiology of R2's bizarre behavior at nursing home 12/31/11 is not entirely clear. However, it does not seem to be any acute process. The patient does have a history of Depression and was some paranoid because apparently he got some IM injection in his buttock area for anxiety, the patient did not like it and he broke the window. R2 reported he did it on purpose and he broke the window and jumped

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F9999	Continued From page 45 out of the window from the rehab and found naked without any clothes in the street." Further review of facility's investigation of R2's 12/31/11 elopement incident validated that facility protocol for resident room window securing included: All resident room windows are to be secured with a screw into the window frames to prevent the window from sliding open more than 6 inches. During 02/03/12 9:15 AM interview, E5 (Maintenance Director) said that on 01/01/12 he was directed to complete an audit of every resident room window for screw placement so the windows are not able to slide open more than 6 inches. E5 said that he found 70% of the short term rehab resident rooms did not have a screw in the window frames to prevent them from fully opening. E5 also said this unit had been remodeled about a year ago and when it was remodeled they forgot to put in the screws in 70% of the rooms' windows. E5 further said that R2's room did not have a screw in the window frame, allowing the window to slide wide open on 12/31/11. During this survey there was 26 residents residing on the short term rehab unit. (A) 300.610a) 300.1210b) 300.1210d)3)6) 300.1220b)2) Section 300.610 Resident Care Policies	F9999		

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F9999	Continued From page 46 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: 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 need for further medical evaluation and treatment shall be	F9999		

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	145006	A. BUILDING _____ B. WING _____	C 02/15/2012

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F9999	Continued From page 47 made by nursing staff and recorded 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These regulations are not met as evidenced by the following: Based on observation, interviews and record review facility failed to: 1) Adequately supervise and initiate interventions to address exit seeking behaviors for 1 of 8 residents (R1) identified by the facility as "At risk for exit seeking / Unit Wanderers." 2) Follow facility's " Elopement / Unsafe Wandering" policy by not completing an elopement risk assessment on admission for 1 resident that did not reside on the Secured Unit,	F9999		

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that was later identified as at risk for elopement, (R1).

These failures also resulted in R1, a 77 year old resident with severe cognitive impairment and an un-steady gait, to exit the facility alone and without her wheelchair on 01/29/12, crossing a heavily trafficked large parking lot and entering an apartment building across the parking lot.

Findings Include:

According to the medical record, R1 is a 78 year old female who was admitted to an unsecured unit at the facility from the acute care hospital at 5:30pm on 01/20/12. R1's admission diagnoses included: Altered Mental Status, Dementia, Diabetes, Osteoporosis and status post right wrist fracture. R1's "Fall Risk Assessment" completed on 01/21/12 noted she was considered a high risk for falls.

Nurses notes documented during a head to toe assessment at 12:32 AM (01/21/12) that R1 appears confused, speech is normal, alert, oriented to person.

12:33 AM, alert and awake, oriented to person, disoriented to time, place, balance difficulty.

12:44AM, able to ID need to void-sometimes, able to use call light, sometimes, able to ask to go to toilet, sometimes. Diagnoses: Dementia/ Alzheimer's

12:46 AM, confused at all times.

01/22/12: 11:18 AM follow up incident, fall at

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hospital prior to admission to this facility, no apparent injury.

01/24/12- Skilled Nursing Observations - Mood, chronic behavior, repetitive behavior. Confused, often easily reoriented. Packs her belongings and asks for a cab to leave nightly.

01/24/12- Social Service Assessment -Admission (completed by nursing) - Behavior: Patient often confused. Patient puts on clothing in multiple layers and states she needs to "take a leave of absence or call a cab." Easily redirected and reassured. Patient aware of how to turn off bed alarm. Monitored closely. Re-educated of need to call for assistance when getting up.

According to the Initial 24 hour Incident Investigation Report completed by E1 (Administrator), on 01/29/12 at approximately 6:15pm, nurse could not find resident to administer her medication. Staff conducted search and resident was found at 7:00 PM in the next building in her old apartment.

The apartment (an assisted living facility) is located next door to the facility approximately 300 yards away. The area between the two buildings consists of parking lots for both facilities. A busy roadway is also nearby to the west of both facilities.

Included in the Initial 24 hour Report under "known facts at this time" E1 documented, "This resident did not exhibit any wandering concerns to staff during her stay here."

E1 was asked on 02/07/12 if a formal risk

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assessment was completed for R1 upon admission. E1 stated the assessment was not completed because R1 was admitted to the facility for therapy from the hospital and was expected to return to her apartment in Assisted Living. E1 further stated R1 was not considered an elopement risk.

Review of E1's full investigation report including staff written statements noted the following:

E11 (nurse) documented in her statement written on 01/29/12 she went to the dining room to give R1 her medication at approximately 6:10 PM. R1 was not in the dining room and E11 continued to search the unit. E11 then went to the front desk and noticed an empty wheelchair with an alarm attached. E11 asked E12 (receptionist) if she had seen R1. E12 stated a woman matching R1's description had come to the front desk with her purse and stated someone was picking her up.

E12 (receptionist) documented in her statement of 01/29/12 an older lady in a wheelchair came up to the lobby at about 6:30 PM and asked if she could leave the wheelchair here so she could go out to her car. She had her purse and keys in her hand. I figured she was a visitor who was borrowing the chair while she was visiting someone. The alarm on the wheelchair went off but I didn't know why and asked her if she knew why. She told me she didn't know and thought it would go off by itself. I thought maybe that was the only available chair not thinking this was a resident since I had not seen her until tonight.

E12 was interviewed by phone on 02/10/12 at 11:30 AM. E12 stated she has worked at the

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facility since 2006. She was trained as a receptionist in basic office skills. E12 further stated the facility kept a book at the front desk of names and pictures of residents who are identified as wanderers. Those residents are from units 1 and 2. They also wear wandering bracelets on their wrists. If a known wanderer tries to leave the building I was supposed to stop them and call a nurse or CNA (Certified Nurses Aide). On 01/29/12 R1 came up to the desk in a wheelchair. She was dressed well, she had a purse and keys in her hand and spoke very well. She didn't look familiar to me. I didn't see a bracelet on her. She asked if she could leave the wheelchair at the door because she was leaving by car. She stood up and didn't appear to have too much trouble walking, she was just a little unsteady so I just thought she had borrowed the chair while she was visiting someone. An alarm went off when she got up. I didn't know why it was alarming or anything about chair alarms. R1 told me she didn't know why the alarm was going off but it would shut off. R1 then left the building. She wasn't in the wanderers' book and they didn't tell me what a chair alarm was for until after all this happened.

The facility's policy on Elopement / Unsafe Wandering Risk Assessment (revised and effective 01/03/12) was reviewed. Specific Procedure / Requirements include the following:

1. The Elopement / Unsafe Wandering Risk Assessment will be completed on admission (within 7 days), quarterly and as needed for a change in resident status. NOTE- If the resident is identified as an elopement risk prior to admission or during the current stay, immediate

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F9999	Continued From page 52 interventions should be implemented. 2. If a new admission or a current resident exhibits behaviors such as; exit seeking, history of exit seeking, wanting to go home or unsafe wandering into hazardous areas the facility should immediately: A. Place the resident in the secured unit. B. Update the wanderer's book with the resident's picture and demographic information. C. Alert the MD and POA (power of attorney) of the behaviors. D. Place a electronic wandering device alarm or (equivalent) bracelet on the resident. E. Place on 1:1 program if exit seeking behaviors are extreme and the resident cannot be easily re-directed. F. Complete the Elopement Assessment. On 02/07/12 E1 confirmed that none of the interventions listed on the elopement assessment policy had been implemented for R1 prior to her elopement from the facility on the evening of 01/29/12. R1 was not assessed until after her elopement and then placed on the secured unit. R5, R6 and R7 who all reside on the unsecured unit are not new admissions were not assessed for wandering/elopement and appropriate interventions until 02/08/12. (B)	F9999		