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F 323	Continued From page 22 policies/procedures, their respective roles in its implementation, and monitoring resident whereabouts and safety. This started on 5/07/12 and continued through this week each shift and then done weekly. All new hires will be inserviced in all the areas that have been cited. -The Administration/designees will continue to ensure compliance with the facility's Elopement Prevention policies/procedures through ongoing routine daily observation of receptionist performance and adherence to lobby door exiting procedures. -The facility will continue to conduct Elopement Drills to evaluate the longterm effectiveness of the Elopement Prevention program, security system mechanicals, and staff response. Results of Elopement Drills and routine daily observations will continue to be incorporated into the facility Quality Assurance process. Trends/patterns will be evaluated with corrective actions implemented as indicated. The aforementioned actions were taken/implemented immediately following the events of 05/06/12.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.610a) 300.1210d)3)6) 300.1220b)3) 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	F9999		

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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

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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

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F9999	Continued From page 24 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These regulations are not met as evidenced by the following: Based on observation, record review and interviews the facility failed to 1) provide adequate supervision and initiate interventions to address exit seeking behavior for 1 of 3 residents (R1) identified as not appropriate for unsupervised outside pass privileges, who subsequently eloped from the facility without staff knowledge in the late night and was located later at hospital emergency room. 2) accurately reassess R1 for elopement risk after history of elopement from facility on 3/28/2012. 3) follow facility missing resident protocol checklist by not completing incident investigation, notify police within 30 minutes after being discovered missing from facility and notify Public Health within 24 hours of incident. These failures resulted in R1, who has a	F9999		

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F9999	Continued From page 25 diagnoses of Alzheimer's Dementia, to exit facility alone again on 5/6/12 at night, crossing a heavily traveled four lane highway, being found by local police on the street and being transported to local hospital. R1 displayed exit seeking behavior on 5/1/12 and no further interventions were put in place. On 5/9/12, E1 stated that there were 26 residents identified as being at risk for elopement. R1 was not one of those residents identified as at risk by the facility. Findings include: R1, a 63 y/o male, was readmitted to facility from acute care hospital on 11/23/11 with diagnoses that includes Dementia, Cerebral Vascular Accident, Seizure Disorder and recent left calcaneal fracture. R1's quarterly Minimum Data Set dated 2/20/2012 under Temporal Orientation and Recall, assessed R1's temporal orientation as unable to correctly report or answer questions regarding year, month and day, and had no recall of previously asked questions. Prior to his elopement on 3/28/2012, R1 resided on the second floor unit where residents are able to leave unit on an unalarmed elevator. R1's community skills assessment dated 1/10/12 assessed R1 as not capable of unsupervised outside pass privileges at this time. R1's elopement risk assessment decision form dated 1/10/12 denoted R1 is not at risk to elope at this time.	F9999		

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R1's care plan dated 2/6/12 denotes under Problem: Resident wanders around the facility without direction which put resident at danger because he can get confused. Goals included: Resident will respond to redirection 100% of the time when displaying wandering behavior per CNA report.

R1's psychiatry report dated 2/26/12 assessed R1 as alert, cooperative, disorientated x 2, thought process slowed, thought content confused, and judgement and insight impaired. Subsequent reports by Z1(psychiatrist), dated 3/31/12 and 4/28/12, show continued disorientation, impaired insight and judgement and continuing confusion.

Nurse notes by E12 dated 3/29/2012 at 5:28AM state "on 3/28/12 upon rounds @ 11:30PM writer notified by CNA that resident was not in room. Writer called each floor to do a full check of each room, B/R"s shower room, closets and dining rooms. The basement was also checked. Patio and courtyard along with parking lot. Called the 3-11 nurse and CNA's. Administrator and DON (Director of Nursing) called. Administrator called hospitals. Writer called local police department. Administrator started to question all staff and residents that he is friends with."

On 5/15/12 at 2:15 pm E12 stated in phone interview that she was informed by CNA that R1 was not found in room on 3/28/12. E12 stated she initiated a search for R1 throughout the unit (2 main north) and outside the facility. E12 stated she did not notify police or notify E1 within 30 minutes after R1 was missing because she was outside looking for R1. E12 stated she called the

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F9999	Continued From page 27 police and administrator about 2:00 am. E12 stated she did not see R1 during initial rounds when she started the shift on 3/28/12. E12 stated R1 would have periods of confusion. E12 stated she called the previous 3-11 nurse of 3/28/12 to see if she had seen R1. E12 stated E15 (LPN) told her R1 was seated at the nurse station. The last charting done on R1 prior to eloping from the facility on 3/28/12 was on 3/15/12. Review of EMS (emergency management run sheet) dated 3/29/12 at 11:02 AM denotes EMS was called for incident type "person down from unknown cause." Patient (pt.) was found sitting on crate in rear lot. Bystanders state pt has been milling around all AM. Pt. answers to all questions appropriately and follow commands. Pt is lethargic. Transported to nearby hospital." The location where R1 was found on 3/29/12 almost 12 hours after eloping from facility was 4.7 miles from facility. R1's emergency record denotes R1 was admitted to ER per ambulance on 3/29/12 at 11:31 AM. Documentation of history and physical states "61 y/o male here for confusion. Acute onset, location generalized, duration unknown, associated with odd behavior. Bystanders called EMS stating he was walking around parking lot for extended period of time, not answering questions. No Seizure activity witnessed by bystanders or EMS. Patient with slow speech, denies history of seizure. Physical exam normal. Patient remains unchanged-not seizing, no clearing. Eyes open, speech slow/clear, repeating question, unable to give info beyond his name. Unsure where he lives, where he stays, or any other info. Pt. is not dischargeable in current	F9999		

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condition, although no explanation for his condition "transient global amnesia but long-term recall seems equally affected. Unable to obtain any family member. Staff from nursing home here to ED. They called 911 and got information. R1 is long-term resident at their facility who wandered off. This is baseline per staff/Social Worker who knows him well. They will take back under their care."

Documentation in nurse notes 3/29/12 denotes R1 returned to facility from hospital #1 by private ambulance at 8:15PM. R1 was readmitted to the 2nd floor unit which is not a secured unit.

E1 (administrator) initiated facility initial 24 hour incident investigation report dated 3/28/12-3/2912 states the following: Event started at 11:30PM-11:45 PM per staff started to check all rooms because of resident history of sleeping in the wrong bed. Full review of facility done. Complete by nurse E12. Spoke with residents, spoke with staff-see interviews, started to call hospital. R1 was at hospital since 3/29/12 (12PM), but because at 5:00AM facility gave R1's wrong birthday, the call at 5:00AM showed R1 not there.

E1 stated in phone interview on 5/16/12 at 2:30PM, concerning the 3/28/2012 elopement, "she was not notified of R1's elopement until 4:00AM, started calling hospitals at 5:00AM, recalling hospitals every couple of hours." Local police records dated 3/29/12 denote police were not notified of R1 missing from the facility until 5:00AM on 3/29/12, 5 1/2 hours after R1 eloped from the facility. E1 stated she did not know why it took so long for the police to be notified by staff

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nurse E12 of R1's elopement, but facility policy requires E1 to be notified immediately. E1 stated all doors were checked and were functioning at time of R1 leaving the facility. E1 stated she could not determine how R1 left the facility on 3/28/12 without staff knowing it.

On 5/16/12, E1 stated interventions after R1's initial elopement of 3/28/12 included: R1 was placed on close monitoring, a receptionist for the front lobby was hired for the 8:00 PM shift till 8:00AM shift though the receptionist only lasted a couple of weeks (April 25, 2012). Staff were inserviced on missing residents and notification of administration, door alarms, and updated elopement book at front desk. E1 also stated R1 was always on elopement review which required R1 not being able to leave 2nd floor, and must be in eyesight of staff, or staff must know that R1 is in bed asleep. There was no final investigation or report of the incident of 3/28/12 and the incident was not faxed to IDPH as required on the back of the facility incident report form which states, "A final investigation report will be sent to the Department of Public Health within 5 working days. R1's care plan was updated on 4/2/12 to reflect the above information.

R1's updated care plan after the first elopement dated 4/2/12 includes under problem "The resident demonstrates movement behavior that may be interpreted as wandering, pacing, or roaming and may go towards exit. Care plan of 4/5/12 denotes "if independent in the community, resident may also become lost or become disorientate in an environment outside of the facility. Approaches included "post a picture of the resident at near the front desk of nursing

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station in a discreet place identifying possible elopement risk. Monitor resident whereabouts, reorient/direct as able, record episodes of wandering, establish routine, divert attention as able and walk along with resident." Care plan also addresses staff response to alarms and to follow facility protocol which includes "If a resident appears to have eloped, then keep one person at main desk to man floor. Send designated staff to the grounds to search the premises, send designated staff through the facility again checking all rooms, even those that are locked. Check closets, bathrooms, etc. Ensure the management are notified, contact resident physicians/family, and police department if the resident not found within 30 minutes. Notify public health within 24 hours of incident. Redirect resident if able and notify nursing staff/administration if episodes of wandering noted." R1 was moved to secure unit and monitor whereabouts at all times.

R1 was not placed in secure unit on 2nd floor until after the elopement of 5/6/12.

Documentation of nursing notes reflected R1 was on elopement watch from 3/30/12 through 4/11/12. From 4/11/12 through 4/29/12 there was no documentation whether R1 had any exit-seeking behavior or whether R1 was still on elopement risk. On 4/30/12 at 4:00PM documentation included R1 asleep majority of shift, no elopement risk during shift.

On 5/1/12 nurse notes of E12 (LPN) reflect the following: "At 6:00AM pt is awake alert, verbally responsive, came to nurse station and told to writer that 'I am sure leaving this place and going

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to my home.' Writer listened carefully. Say nothing and direct to his room, sit with him for while. Writer started making morning rounds, call made to first floor nurse (E14) LPN that pt is trying to leave the facility. Close observation maintained. 2nd time writer saw resident running so fast to leave the unit. Writer follow-up and directed resident to room, asking resident what is address of place you want to go resident states 'I am not letting you know.' Resident remains on close observation, day staff and night staff aware. To monitor closely per staff."

There was no documentation regarding R1's exit seeking behavior from 5/1/12 until R1 was discovered missing from facility on 5/6/12 at 11:15 PM.

E12 (LPN) stated during phone interview on 5/14/12 that on 5/1/12 she observed R1 running onto unalarmed elevator on 2nd floor to get to the 1st floor. E12 stated she did report incident to nurse (E14) but did not notify social service regarding R1's exit seeking, because they come in later. E14 (LPN) stated on phone interview on 5/14/12 she was not notified by E12 regarding R1's behavior of 5/1/12 and was only aware of R1's previous elopement of 3/28/12, because she heard about it.

On 5/9/12 during investigation of elopement of 3/28/12, upon review of R1's nurse notes, it was discovered R1 had eloped again on 5/6/12 without staff awareness. Nursing notes entered by E14 and dated 5/7/12 at 2:23 AM denote "During shift change rounds at 11:15 PM, noted patient not in his bed, room or unit facility searched all floors rooms and stairwells. Patient

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F9999	Continued From page 32 not located in building, administrator and police notified of missing person and report initiated at 11:30PM. Called around to neighboring hospital, resident was located at hospital at 12:30 AM, was brought into ER by a police officer. Social services director went to hospital to verify patient and patient was being admitted." Hospital #2 record review denotes R1 arrived in the ER on 5/6/12 at 11:22PM per ambulance with complaints of abdominal pain and shortness of breath. R1's history and physical dated 5/7/12 denotes: Reason for Admission: Acute Renal Failure, Dehydration History of Present Illness: The patient is a 62 y/o male with significant past medical history of intracranial hemorrhage, CVA, Diabetes Mellitus, Dementia who was brought to ED via EMS after being found by the police wandering the street in a hospital gown. Pt found confused and disorientated stating the he "left a hospital on the north side of Chicago." Pt is a resident at long term care facility. Pt was unable to provide any past medical history or events that led to this hospitalization. All past medical history obtained from NH (nursing home) via telephone and via fax. Currently pt is alert and orientated to self only. R1 was discharged back to facility on 5/7/12. E1 stated on 5/10/12 that R1 was placed on a secured unit upon readmission due to elopement of 5/6/12. A request was made to review facility elopement risk book at front desk from receptionist E16 on 5/9/12. Surveyor requested to review R1's elopement risk assessment, E16 responded, "R1 is not an elopement risk."	F9999		

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Review of R1's assessment revealed R1's last elopement risk assessment was done on 1/10/12. A community skills assessment was completed on 3/20/12 and 4/4/12 assessing R1 as not appropriate for access to community pass privileges due to R1 not being alert and orientated.

E17 (social service director) stated in interview on 5/10/12 he does not consider R1 as an elopement risk due to the fact when R1 leaves the facility he does have a "purposeful action." E17 stated R1 leaves because he has family/money problems. E17 stated R1's confusion can vary from time to time.

E1 stated on 5/10/12 R1 has poor insight in decision making and R1's assessment of community skills and not being suitable for unsupervised pass is due in part to R1's Dementia.

Review of R1's updated elopement risk assessment of 5/7/12 revealed the following computerized documentation:
["1. Does resident have a history of elopement/elopement attempts?Yes, but he know were he is going, has community skills but not appropriate to be in community independently due to AOx1 or x2 (ao changes at times due to dementia).
2. Does resident spend time near and around exit doors/front doors in an attempt to elope? No.
3. Does resident have a diagnosis of Dementia/Alzheimer's? Yes.
4. Does resident have severely impaired skills or decision making. Yes, but has impaired memory which may affect decisions at times.

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5. Does resident express wanting to leave the facility without authorization? No, because if resident expresses that he "events or occurrences that he needs to be addressed" to staff but is redirected when staff says he is unable to do so.
6. Is resident unrespectable when wandering or spending time at exit doors? No
7. Is resident able to ambulate with /without assistive devices? Yes.
8. Are there any special environmental/safety considerations for this outside of the facility's standard protocols that need to be made? No.
9. Is resident at risk to elope (If 1. or 2. answer yes, resident will be at risk. If 3. or 4. AND 5. or 6. answer, then resident is at risk. Care plan if need if resident is at risk dn resident will be placed on Elopement risk protocol) No. Resident is not at risk for elopement due to addressing staff when he wants to be leave. When he does want to leave the facility, he is doing so of his belief of a purposeful task and alerting staff beforehand. Staff will redirect resident as appropriate to remain the facility. If resident does require to leave the facility, staff will escort resident due to resident not being appropriately for resident to be in the community independently due to dementia. Resident was placed on the memory care floor that will allow for a failure free environment and constant redirection or reassurance."]

On 5/14/12 during review of R1's risk elopement assessment dated 5/7/12 surveyor asked why the assessment does not assess R1 as an Elopement Risk. On 5/14/12 E 1 redid the assessment which now identifies R1 as having exit seeking behavior, as being at risk to elope,

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(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
F9999	Continued From page 35	F9999		

and assessing R1 as wanting to leave the facility without authorization. E 1 stated R1 was placed on Elopement Risk Protocol.

On 5/10/12 surveyor observed R1 sitting in the dining room on the secure unit of the 2nd floor. R1 was alert but confused to time, date and place. R1 was asked if he ever left the building and R1 nodded his head up and down. R1 was asked how he would leave the building. R1 responded, "by the front door." R1 was asked if he ever heard alarms or bells when he left. R1 shook his head no.

On 5/10/12 E1 stated immediately after R1's elopement of 5/6/12 she was notified by staff immediately, facility and area were searched, police were notified and surrounding hospitals called. E1 stated door alarms were checked and working. E1 stated during the initial investigation staff were asked if they had heard any alarms in the evening of 5/6/12, staff reported hearing an alarm at 8:30PM, but was reported to be a family member leaving the facility after visiting hours.

On 5/14/12 at 3:12 pm, E13 (CNA) who filled in as a receptionist on Sunday 5/6/12 stated "I worked 4:30 PM-8PM. I announced to visitors that visiting time is over. I know everybody left because I know who comes in and who comes out. I have them sign." E13 stated she then locked outside front door with key and then turned on alarm on the inside lobby door and waited for green light to go on indicating the door is alarmed. (Demonstrated to surveyor by E13 on 5/10/12.) E13 stated she then went upstairs to 2nd floor prior to leaving facility. E13 stated she saw R1 sitting in dining room on 2nd floor (not

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	145714	A. BUILDING ______ B. WING ______	C 05/18/2012

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F9999	Continued From page 36	F9999		

secured unit).

E1 stated in interview on 5/14/12 she had not completed an investigation of how R1 got of the facility on 5/6/12, because "you guys came in right after." When asked how she thinks R1 got out E1 stated "Don't know."

The facility elopement book located at receptionist front desk identifying residents at risk for elopement included a protocol checklist that included the following :

"Facility current Missing Resident Protocol Checklist states once it has been determined that there is a possible elopement/missing resident, this checklist may be used to assist in following procedure. A system will be established which will be utilized during drills and in the event of elopement."

-If alarm has sounded, check area of alarm to see if any resident is in the surrounding area.
-If no one is the area, send one person out the door that alarmed to check the premises,
-Designate a room by room check, sending one person to each hallway to initiate a head count.
-Have each designated person report the count back to the charge nurse on duty.
-If a resident appears to have eloped, then keep one person at main desk to man floor.
-Send designated staff to the grounds to search the premises.
-Send designated staff throughout facility again checking all rooms, even those that are locked. Check closets, bathrooms, etc.
-Ensure that management is notified (Administrator/Director of Nursing)

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F9999	Continued From page 37 -Contact resident physician -Contact resident family -Contact the police department if the resident is not found within 30 minutes -Try to identify what the resident was wearing and any other identifying items that may be helpful in the search -Chart incident clearly and concisely -Complete incident investigation -Notify Public Health within 24 hours of incident. Facility Elopement Policy Statement states nursing personnel must report and investigate all reports of missing residents. Policy Interpretation and Implementation states under section 4. Should an employee discover that a resident is missing from the facility, he/she should: a. Determine if the resident is out on an authorized leave or pass. IF NOT; b. Make a thorough search of the building(s) and premises. IF NOT LOCATED; c. Notify the Administrator and the Director of Nursing Services; d. Notify the resident's legal representative e. Notify the attending physician f. Notify law enforcement officials g. If necessary, notify volunteer agencies h. Provide search teams with resident identification information; and i. Make an extensive search of the surrounding area. 5. Upon return of the resident to the facility, the Director of Nursing Services or charge nurse should	F9999		

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F9999	Continued From page 38 a. Examine the resident for injuries. b. contact the Attending physician and report findings and conditions of the resident C. notify the resident's legal representative d. notify search teams resident has been located. e. Completa and file and incident report f. Make appropriate entries into the resident's medical record: g. Complete investigation report and h. Amend resident's care plan as appropriate. (A)	F9999		