| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145625 | A. BUILDING _____ B. WING _____ | C 06/16/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CALIFORNIA GARDENS N & REHAB C** | **2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608** |

| (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 |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>Complaint Investigation<br>1583007/ IL77727- F279 and F323 cited.<br><br>Incident Report Investigation<br>IRI of 6.5.15/ IL77711- F279 and F323 cited. | F 000 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to develop an accurate care plan that addressed wandering status for one of three residents (R1) reviewed for comprehensive care | F 279 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145625 | A. BUILDING _____ B. WING _____ | C 06/16/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CALIFORNIA GARDENS N & REHAB C** | **2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608** |

| (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 |
|---|---|---|---|---|
| F 279 | Continued From page 1<br>plans in a sample of 5 residents.<br><br>Findings include:<br><br>R1 was admitted to the facility on 4.30.15 from the hospital following a fall with diagnoses including: Closed Facial Bone Fracture, Difficulty Walking, Muscle Weakness, ETOH (alcohol) dependence/drunkenness and Mechanical Complication due to Ocular Lens Prosthesis.<br><br>R1's MDS (Minimum Data Set) of 5.7.15 documents wandering behavior was not exhibited. MDS of 5.30.15 documents wandering behavior occurred one to three days.<br><br>Progress Notes of 5.3.15 and 5.4.15 document R1 refused to stay in bed, had to place in wheel chair at Nurses Station and, as non-compliant, trying to get on the elevator, into other resident's room, needs to be watched at all times and is a danger to himself. E4 (LPN-Licensed Practical Nurse, 6.16.15 at 11:09 AM) said E1 tried twice to get on the elevator and get out of the building on 5.4.15.<br><br>Progress Note of 5.6.15 documents received R1 up in wheelchair at the Nurses Station. Appeared restless as evidenced by attempting to keep getting out of wheelchair and attempting to walk. E17 (LPN, 6.12.15 at 1:12 PM) said R1 kept trying to get out wheelchair, trying to get away from the Nurses Station.<br><br>Progress Note of 5.18.15 documents resident observed by staff at back exit door setting off alarm. Resident redirected, placed at Nurses Station. Resident constantly trying to leave the Nurses Station. E6 (LPN, 6.12.15 at 12:08 PM) | F 279 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145625 | A. BUILDING _____ B. WING _____ | C 06/16/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CALIFORNIA GARDENS N & REHAB C** | **2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608** |

| (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 |
|---|---|---|---|---|
| F 279 | Continued From page 2<br>said R1 was already at Nurses Station when she started her shift. E6 was told that R1 had to be closely monitored because of wandering. E6 said when staff left Nurses Station to complete their rounds, R1 went to the exit door (west stairwell) and set the alarm off by opening the door. E6 said she told the 7-3 shift to keep an eye on R1. She said she knew R1 was a wanderer but was not aware of any elopement precautions.<br><br>Progress Note of 6.2.15 documents R1 noted this morning at exit door with his belongings stating he has to go to work. E16 (3rd Floor Unit Manager, 6.11.15 at 4:50 PM) said R1 confirmed the information documented in this progress note.<br><br>Review of R1's medical record documents an elopement care plan was not initiated until 6.2.15 when it was determined resident was at risk for elopement and should be placed on elopement risk protocol.<br><br>The facility's elopement policy and procedure (Elopement Risk, #2) states: "Any resident identified at risk to elope may have the Elopement Risk identified and included in the Interim Plan of Care. A comprehensive elopement prevention plan of care will be developed at the first care plan meeting. The plan will be reviewed at least every 90 days or more often if necessary. This policy was not followed. | F 279 | | |
| F 323 SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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 | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145625 | A. BUILDING _____ B. WING _____ | C 06/16/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CALIFORNIA GARDENS N & REHAB C** | **2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608** |

| (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 |
|---|---|---|---|---|
| F 323 | Continued From page 3<br>prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to have a monitoring system in place that alerts the staff when a resident is exiting out of a window, ensure electronic monitoring devices were in place and functioning for a resident, have a specific care plan or revise the care plan for a resident's wandering or elopement behavior and follow the physician's order for placing an elopement bracelet on a resident. This applies to one of three residents (R1) reviewed for safety in a sample of five.<br><br>As a result, R1 exited out of a window on the facility's third floor and fell to the ground below. R1 sustained multiple injuries including but not limited to: bleeding in the brain, fractures of lumbar/ lower back and pelvic areas. R1 later died from his injuries.<br><br>Findings include:<br><br>R1's face sheet documents resident was admitted to the facility on 4.30.15 from the hospital following a fall with diagnoses including: Closed Facial Bone Fracture, Difficulty Walking, Muscle Weakness, ETOH (alcohol) dependence/drunkenness and Mechanical Complication due to Ocular Lens Prosthesis.<br><br>R1's MDS (Minimum Data Set) of 5.7.15 documents wandering behavior was not exhibited. MDS of 5.30.15 documents wandering | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145625 | A. BUILDING _____ B. WING _____ | C 06/16/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CALIFORNIA GARDENS N & REHAB C** | **2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608** |

| (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 |
|---|---|---|---|---|
| F 323 | Continued From page 4 | F 323 | | |

behavior occurred one to three days.

The facility's initial incident report of 6.5.15 documents R1 was last seen at 1:15 AM and while making rounds on 6.5.15 at 1:35 AM, resident was not in his room. Staff searched the entire facility. R1 was found outside the facility. E5 (Nursing Supervisor, 6.9.15 at 6:54 AM) said she found R1 in the hedges directly below his room.

R1's hospital record (Discharge Summary 6.7.15) documents R1 sustained a frontal parietal subdural hemorrhage and subarachnoid hemorrhage, L1 compression fracture, right hemopneumothorax, comminuted right upper extremity fractures and an unstable pelvic fracture.

A certificate of death worksheet with a certified date of 6.11.15 listed R1's cause (s) of death on 6.7.15, as multiple injuries and fall from height.

Elopement and Fall Risk Screens completed 4.30.15 document R1 "was not at risk to elope at this time" and was a high fall risk with a score of 17. A fall care plan was initiated on 4.30.15 and included these interventions: "Staff to ensure bed alarm is in place and functioning every shift." and "Staff to monitor resident closely when out of bed."

6.16.15 at 11:09 AM E4 (LPN-Licensed Practical Nurse) said, R1 tried twice to get on the elevator and get out of the building on 5.4.15. He said he did not contact R1's physician regarding resident's exit seeking behavior.

Progress Notes of 5.3.15 and 5.4.15 document

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145625 | A. BUILDING _____ B. WING _____ | C 06/16/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CALIFORNIA GARDENS N & REHAB C** | **2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608** |

| (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 |
|---|---|---|---|---|
| F 323 | Continued From page 5<br>R1 refused to stay in bed, had to place in wheel chair at Nurses Station and, as non-compliant, trying to get on the elevator, into other resident's room, needs to be watched at all times and is a danger to himself.<br><br>6.12.15 at 1:12 PM E17 (LPN) said, R1 kept trying to get out wheelchair, trying to get away from the Nurses Station.<br><br>Progress Note of 5.6.15 documents received R1 up in wheelchair at the Nurses Station. Appeared restless as evidenced by attempting to keep getting out of wheelchair and attempting to walk.<br><br>Progress Note of 5.18.15 documents resident observed by staff at back exit door setting off alarm. Resident redirected, placed at Nurses Station. Resident constantly trying to leave the Nurses Station. 6.12.15 at 12:08 PM E6 (LPN) said, R1 was already at Nurses Station when she started her shift. E6 was told that R1 had to be closely monitored because of wandering. E6 said when staff left Nurses Station to complete their rounds, R1 went to the exit door (west stairwell) and set the alarm off by opening the door. E6 said she told the 7-3 shift to keep an eye on R1. E6 did not inform R1's physician of resident's behavior. She said she knew R1 was a wanderer but was not aware of any elopement precautions. E6 said she did not read R1's care plans or MDS.<br><br>Progress Note of 6.2.15 documents R1 noted this morning at exit door with his belongings stating he has to go to work. E16 (3rd Floor Unit Manager, 6.11.15 at 4:50 PM) said R1 confirmed the above entry. | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145625 | A. BUILDING _____ B. WING _____ | C 06/16/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CALIFORNIA GARDENS N & REHAB C** | **2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608** |

| (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 |
|---|---|---|---|---|
| F 323 | Continued From page 6<br><br>6.16.15 at 11:35 AM Z3 (Physician) said, He was not notified by facility staff of any exit seeking/unusual behavior exhibited by R1. Z3 said had he been notified, he would have ordered a psychiatric consult or sent R1 to the hospital for evaluation and treatment.<br><br>6.16.15 at 11:17 AM Z2 (Nurse Practitioner-NP ) said, she examined R1 on 6.2.15 after she was notified of resident's exit seeking behavior. She said she ordered a elopement bracelet to be placed on R1 and was unaware that order had not been followed.<br><br>According to the facility's (undated) elopement risk procedures the staff can identify evidence of exit seeking behavior when the following occurs: Packing clothing in bags and suitcases, Pacing back and forth toward doors and windows, Putting on clothes, Always talking about leaving and Attempting to leave unit.<br><br>R1's care plan was initiated on 4.30.15, there was no immediate revision or modification to the care plan to address R1's exit seeking behavior. R1's medical record documents an elopement care plan was not initiated until 6.2.15 when it was determined resident was at risk for elopement and should be placed on elopement risk protocol. The facility's elopement risk procedures included the use of electronic monitoring system.<br><br>6.10.15 at 11:54 AM and 6.12.15 at 1:40 PM R4 (R1's roommate) said, R1 would get up at night, get dressed, put shoes on and leave the room; facility staff "lost " R1 twice. On the day of the incident R4 said, he heard R1 banging so loud, it | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145625 | A. BUILDING _____ B. WING _____ | C 06/16/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CALIFORNIA GARDENS N & REHAB C** | **2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608** |

| (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 |
|---|---|---|---|---|
| F 323 | Continued From page 7<br>woke R4 up and said he was surprised staff did not respond; R1 did not have a bed alarm on his bed (R4 is aware of what a bed alarm is as R4 has one on his bed) and thinks the room to their room was open when R1 was banging.<br><br>6.9.15 at 6:10 AM E4 (LPN-Licensed Practical Nurse, ), 6.9.15 at 7:31 AM E6 (LPN ), 6.12.15 at 10:47 AM E9 (CNA-Certified Nursing Assistant) and 6.9.15 at 7:58 AM E7 (CNA, ) denied hearing anything (alarms, banging) on the day and time R1 exited out of a third floor window.<br><br>6.12.15 at 1:12 PM E17 (LPN) said, R1 had a bed alarm. 6.12.15 at 2:05 PM E18 (LPN) said, R1 had both a chair and bed alarm and fall precautions/interventions were not discontinued. 6.12.15 at 2:17 PM E21 (CNA) said, R1 had a bed alarm. | F 323 | | |