STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146058	A. BUILDING _____ B. WING _____	C 09/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSTON NURSING & REHAB CTR	**1300 OAK AVENUE EVANSTON, IL 60201**

(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 Complaint Investigation: #1392218/IL 63534 - No deficiency #1391281/IL 62418 - No deficiency Incident Investigation: Incident of 03/12/13 /IL 62260 - F323	F 000		
F 323 SS=D	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, interview and record review the facility failed to protect 1 of 5 residents (R3) reviewed for accidents/incidents and elopement risk. This failure resulted in R3 climbing out of a second floor window on a secured floor. R3 was hanging upside down on the outside of the building with knotted sheets attached to his ankle. 911 had to be called to remove R3 from the outside of the building; R3 was transferred to a local hospital for evaluation. Findings Include: September 10, 2013 at 10:15 am, the bedroom and bathroom window on the secured second floor was checked for the safety of the residents.	F 323		

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

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The windows had a very thin frame surrounding them and are the type of windows that can be opened by pulling the windows forward to wash the outside of the window from the inside. The windows had 4 screws that were partly nailed in and bent forward on the bottom half of the window with two nails in the top half of the window.
September 10, 2013 at 10:40 am, E1 (Administrator) was asked if the windows were secured with the screws/nails before R3 ' s elopement. E1 during interview stated No, it was after R3 got out of the windows and was found hanging from the building. E1 stated no one could have predicted that a resident would go out of a second floor window.
September 12, 2013 at 12:40 pm via telephone interview, E3 Certified Nursing Assistant (CNA) at the time of the incident is now a nurse. E3 stated R3 woke up at 4:45 am and asked for a bed sheet and a towel to take a shower. E3 stated she gave R3 the towel and sheet and later went to R3's room because; she did not hear any water running in the bathroom.

E3 stated during interview that on March 12, 2013 at 4:45 am, she knocked on R3's room door and did not get an answer. E3 stated that she tried pushing against the door but could not open it. E3 stated she went to the other bedroom to try and open the door from the other side; because the rooms share a bathroom together. E3 stated the other door was very hard to open and she pushed and pushed, but was not able to get into the room. E3 stated that R3 used the sheets to anchor the doors shut so staff could not open them. E3 stated she could see through the opening of the door that sheets were knotted

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together and she went to page for help from another CNA and the nurse. E3 was asked did she get into the room and look down to see R3 hanging in the sheets. E3 stated no, I could not get through the doors. I called the nurse a to let her know that R3 was not answering me and that I could see sheets tied together hanging from the window.

September 12, 2013 at 12:12 pm, E2 (Social Service Director) stated that she was told from the previous Director of Nursing (E4) who is no longer employed by the facility that R3 was yelling help, help and knocking on her window. E2 stated during interview that E4 would arrive at the facility in the early morning hours. E4 told E2 she was startled by the knocking on her window and the cry for help that early in the morning.

E2 stated that E4 said when she opened the window she was surprised to see R3 hanging upside from the building with the sheet tied to his ankle. E2 stated that E4 called 911 and went outside to wait for the police to get R3 down. E4 stated E2 told her that R3 was removed by 911 and able to walk to the ambulance without any known injuries. R3 was taken to the local hospital for evaluation.

E2 was asked if she was familiar with R3's history and E2 stated yes, that R3 had been admitted to the facility twice before the incident. E2 stated that R3 had a history of elopements from previous admissions. E2 stated that R3 is a chronic alcoholic and has traumatic brain injury with other psychiatric disorders. R3's medical diagnosis and previous admission notes confirm E2's statement.

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Record Review:
R3 is a 70 y/o with medical diagnoses of Pathological Alcoholism, Psychiatric Disorders, Traumatic Brain Injury (TBI) and Altered Mental Status (AMS). R3 had 2 previous admissions to the facility within the last 18 months. R3 has drunken mouth wash and other products that contain alcohol to help with withdrawal symptoms. R3 has attempted and has been successful with previous elopements from other facilities.
Elopement Risk Assessment Procedure/Policy:
An elopement risk assessment will be performed during the admission process; reviewed/updated quarterly and when there are documented changes in mood or behavior which indicate the potential for elopement.
5. Interdisciplinary care plans of those at risk of elopement will address specific interventions that are unique to the risk factors.
Elopement Risk Assessment for R3:
1. History of wandering/elopement and /or does resident verbalize a strong desire to leave = Yes
2. Does resident hang around facility exits or stairways = Yes
3. Responds poorly to staff re-direction when roaming into areas that are " off limits " or unauthorized. = YES
4. Has the physical ability to leave the building = Yes
Social Service Care Notes:
February 13, 2013, R3 is agitated and voicing intent to leave the facility to go to the cash station. R3 is seeking alcohol and voiced intent to go to his ex-spouse house.
Behavior Monitoring Sheet:
2/15/13, R3 is uncooperative with staff. 2/28/13,

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F 323	Continued From page 4 R3 is anxious and restless. 03/02/13, R3 is uncooperative and anxious. 03/04/13, R3 is withdrawn. 03/05/13, R3 is restless. 03/06/13, R3 is delusional, restless and anxious about leaving the 2nd floor. 03/07/13, R3 is anxious. On 03/0813, R3 is still anxious and restless. March 9, 2013, R3 displays psychosis, is delusional, uncooperative, anxious and restless. March 10, 2013 at 1:47 pm, R3 presents withdrawn and restless; at 9:19 pm R3 presents anxious. Nursing Notes: March 4, 2013, R3 is feeling down, depressed and hopeless, likes spending time in room. March 6, 2013, R3 is delusional and restless with little interest/pleasure in doing things. Moving around a lot more than usual and pacing the halls during shifts. March 9, 2013, R3 presents with psychosis, delusions, uncooperative, anxious and restless. R3 has trouble concentrating, fidgety/restless and moving around on the unit a lot more than usual. The nursing notes, care plans or social service notes do not state any new interventions to address R3 ' s escalating behaviors during the period of 2/15/13 - 03/12/13. The comment section on the progress notes only has elopement precautions. It does not state what kind or types of precautions are to be implemented in preventing R3 from eloping.	F 323		