STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001333	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

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S9999	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS

300.1210b)
300.1210d)2)3)6)
300.1220b)3)
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.

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:

2) All treatments and procedures shall be administered as ordered by the physician.

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

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1 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: 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) THESE REGULATIONS WERE NOT MET AS EVIDENCED BY: 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	S9999		

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S9999	Continued From page 2	S9999		

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.

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.

Findings include:

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.

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.

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)

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S9999	Continued From page 3	S9999		

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 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.

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.

Progress Note of 5.6.15 documents received R1 up in wheelchair at the Nurses Station. Appeared restless as evidenced by attempting to keep

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S9999	Continued From page 4 getting out of wheelchair and attempting to walk. 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. 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. 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. 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.	S9999		

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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.

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.

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 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.

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.

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

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S9999	Continued From page 6 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. (B)	S9999		