STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 1690329/IL82825 - No deficiency 1690824/IL83378 - No deficiency 1690934/IL83506 - F323 cited	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 300.2900d)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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) COMPLETE DATE
S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: 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: 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. (Section 2-107 of the Act) Section 300.2900 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. These requirements were not met as evidenced by: Based on interview and record review the facility	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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) COMPLETE DATE
S9999	Continued From page 2	S9999		

failed to 1) care plan and implement fall prevention interventions to address a cognitively impaired resident not seeking staff's assistance for toileting, and 2) respond quickly to a door alarm, provide monitoring and supervision to prevent a resident's elopement from the facility. This applies to one of three residents (R1) reviewed for falls and supervision in a sample of 9.

As a result of the failure, R1 who had a history of falls, was found by a staff member on the floor in a bathroom. R1 experienced a fall and sustained a right hip fracture which required a surgical procedure to repair.

Findings include:

1. According to January 2016 POS (Physician Order sheets) R1 was diagnosed with but not limited to syncope with collapse, aphasia following cerebral infarction, hypertension encephalopathy, history of falling and muscle weakness.

R1's December 4, 2015, MDS (Minimum Data Set) Comprehensive Assessment documented R1 was cognitively impaired and depended on staff member for physical assistance with activities of daily living

R1's November 2015 through January 2016 Nurses' notes and incident reports included documentation as follows:
-11/27/15: (R1) tried to get up and slipped hitting (R1's) butt

-1/9/16: Heard the bed alarm sound and right away checked, found (R1) lying on left side on the floor; (R1) stated that (R1) is trying to walk and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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) COMPLETE DATE
S9999	Continued From page 3	S9999		

lost balance.

-1/15/16 at 2:20 am: Heard the sound of the bed alarm and went inside the room. Observed (R1) sitting on the floor with legs extended beside (R1's) bed. (R1) stated, "I slid on the floor and I'm not hurt." Able to ambulate and assisted to the washroom.

-1/16/16 at 12:20 am: Answered call light from another room, passed by (R1's) washroom and observed (R1) lying on back on the floor with right knee flexed towards the left leg, with redness noted below and with complaints of pain when moving ...transferred to (local hospital) accompanied by two paramedics at 1:35 am.

According to the above, R1 had a total of 4 fall incidents during facility admission.

Hospital Records documented, 1/16/16 X-ray of pelvis with Impression: Intertrochanteric fracture of the right femur. Fracture fragments are mildly displaced. The hospital's medical progress notes by the hospital physician on 1/17/2016 documented: R1 had a procedure in which a intramedullary rodding was done for repair of the closed intertrochanteric fracture of the right hip.

R1's care plan documented the following :
-Date initiated: 11/30/15
Focus:
The Resident is at high risk for falls related to recent fall last month, impaired balance during transitions, gait problems such as unsteady gait even with mobility aid or personal assistance, impulsivity or poor safety awareness, cognitive impairment.

Goal:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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) COMPLETE DATE
S9999	Continued From page 4 The resident will be free of falls through the review date Interventions for R1 on 11/30/15: Be sure call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Anticipate and meet the resident's needs. The resident uses (chair/bed) electronic alarm. Ensure the device is in place as needed. PT/OT (Physical therapy/Occupational therapy) consultation Provide resident with a safe environment. Move the patient close to the nurses' station. Monitor /document/report as needed to physician Maximize the resident's time out of bed Keep needed items, water etc, in reach Keep furniture in locked position Ensure that resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair -Interventions for R1's fall on 1/9/16: Reminded resident to ask assistance from staff for ambulation Encouraged to use assistive device for locomotion -Interventions for R1's fall on 1/15/16: Refer to maintenance director to check bed/mattress for any issues Ensure proper positioning on the center of the bed when sleeping to prevent sliding off Discontinue bed alarm During interviews with E8 (Registered Nurse), E14 and E15 (both Certified Nursing Assistants) conducted on 3/02/16 all reported, R1 used a	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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) COMPLETE DATE
S9999	Continued From page 5	S9999		

wheelchair and did not use a walker

Z2's (Nurse Practitioner) progress notes on 1/9/16 documented:
Neurologic: A, O (Alert and oriented) 1 to 2, at baseline
Problem: Episode of weakness
According to E1 (Administrator) on March 3, 2016 at 12:00 pm, (Z2) diagnosed (R1) with Generalized muscle weakness which may have contributed to the fall

There was no documentation on nurses' notes and on Documentation Survey report that assistance was provided for toileting, transfer and bed mobility prior to the fall on 1/15/16

According to a telephone interview with E8 (Registered Nurse) on March 2, 2016 at 11:42 am, R1 will get up to go use the bathroom, even without assistance. E8 stated that R1 was assisted to use the bathroom after the fall on 1/15/16. E8 stated that it was determined that R1 needed to use the bathroom at that time. E8 also stated that R1 uses a regular bed.

There was no documentation on nurses' notes and documentation survey report that staff offered assistance to R1 on 1/16/16 prior to R1's fall.

On February 28, 2016 at 5:00 pm, E6 (Licensed Practical Nurse) stated that R1 is alert and oriented to self and Z3 (R1's family) and would always ask where Z3 is. E6 stated that R1 exhibit some behaviors and at times confused and forgetful. E6 stated that R1 "needs assistance for safety reasons."

On March 1, 2016 at 11:00 am, E4 (Restorative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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) COMPLETE DATE
S9999	Continued From page 6	S9999		

Nurse) stated that R1 is alert and oriented 1 to 2 and was identified as at risk for falls. E4 stated that R1 had 4 fall incidents while in the facility. E4 stated that a toileting schedule was not put in place for R1 because R1 was identified as continent of bowel and bladder. E4 confirmed that R1 needs assistance with toileting and transfers, and that is it safer if R1 is assisted, and also confirmed that this was not in the fall care plan interventions. E4 stated that E4 planned to put R1 in a toileting schedule after R1 returns to the facility.

On March 2, 2016 at 1:52 pm, Z1 (Physician) was interviewed via telephone. Z1 confirmed that R1 has periods of confusion. Z1 stated that R1 needed monitoring. Z1 stated that (Z1) had seen (R1) at a local hospital after R1 obtained a fracture after falling at the facility.

On March 2, 2016 at 11:42 am, E8 was interviewed via telephone. E8 stated that R1 is alert and oriented to self. E8 stated that R1 "does not remember my name." E8 stated that usually R1 would go to the bathroom per self. E8 stated that the last 2 fall incidents happened during E8's shift (11-7 shift). E8 stated that R1 would usually stand, move about in the room and use the washroom. E8 stated that R1 needs assistance with ADLs and needs assistance for safety. E8 stated that R1 can move about but "needs assistance." E8 confirmed that R1 is not on any toileting schedules but needs assistance with going to the bathroom. E8 stated that "I think the bed alarms are necessary, especially at night, so that we know that (R1) is trying to get up. They usually tell us if there is a change in the interventions, (R1) had a bed alarm. For R1's fall on 1/16/16, I just don't remember hearing the alarm or if I turned it off once I got there."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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) COMPLETE DATE
S9999	Continued From page 7	S9999		

On March 2, 2016 at 3:21 pm, E15 stated that R1 is alert to self and to person. E15 stated that R1 goes to the bathroom per self but it is safer for R1 to be assisted with transfers and toileting.

On March 2, 2016 at 12:35 pm, E14 was interviewed. E14 stated that R1 is alert and oriented to wife and that R1 needs assistance with transfer and toileting. E14 added that R1 did not use a walker but used wheelchair when (R1) goes to the washroom by self. E14 stated that R1 can ambulate but for safety reasons, R1 needs assistance.

The facility's undated policy on Fall Occurrence documents in part:
It is the policy of the facility to ensure that residents are assessed for risk for falls and interventions are put in place to prevent them from falling. Those identified as high risk for falls will be provided interventions to prevent falls.

2. The facility's 12/31/15 incident report for R1 documented: E6 (Licensed Practical Nurse-LPN) was making rounds and noticed that (R1) was not in room; bathrooms were checked, dining room and other resident's rooms. (E6) also called first floor. Was in the process of looking for (R1) when (Z3 - R1's family) called and stated that (R1) called and that (R1's) at the gas station. (E6) sent (E14 - CNA) to get (R1) back to the facility.

On February 28, 2016 at 5:00 pm, E6 stated that on 12/31/15 at around 8:15 pm, E6 was notified by E15 that E15 could not find R1. E6 stated that a facility-wide search was conducted. E6 stated that in the middle of the search, Z3 called the facility and stated that R1 was at the gas station and had called Z3. E6 stated E6 sent E14 to get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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) COMPLETE DATE
S9999	Continued From page 8	S9999		

R1 from the gas station and R1 was brought back to the facility at around 9:00 pm. E6 denied hearing exit door alarm going off during the time of the incident, "there were too many sounds at that time." E6 stated that when E6 asked R1 why R1 went outside, R1 stated, "I wanted to call (Z3). "

On March 2, 2016 at 3:21 pm E15 stated that E15 had seen R1 in the room at around 7:30 pm. E15 stated, "When I went to (R1's) room, I didn't find (R1). I checked in the bathroom and every room. I told (E6) about it. I went to the 3rd floor and 1st floor and I even went and asked (E16-Receptionist). They told me that they didn't see R1. As soon as I came back, Z3 had called (E6) and was told that (R1) was at the gas station and then R1 returned to the facility. I asked (R1) why (R1) went out, (R1) said that (R1) was looking for (Z3) and also wanted to buy cigarettes." E15 stated that R1 had a monitoring device on the ankle but did not hear any alarms go off on the 2nd floor.

On March 2, 2016 at 12:35 pm E14 stated, E14 was asked by E15 if E14 had seen R1. E14 stated that the last time E14 had seen R1 was during dinner time. E14 stated that they were asked to search the rooms for R1. E14 stated that when E6 received a call from Z3, E6 had instructed E14 to go to the gas station. E14 stated that R1 was inside the gas station talking to the clerk there and when asked why R1 went there, R1 told E14 that R1 wanted to call Z3. E4 stated that R1 had a monitoring device and did not hear any alarms go off on the second floor.

E6, E14 and E15 stated that when a resident has a monitoring device and come near the elevator, the alarms get triggered; the elevators stop and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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) COMPLETE DATE
S9999	Continued From page 9	S9999		

open but won't close or move unless a staff member deactivates the alarm. E6, E14 and E15 also stated that if a resident with a monitoring device comes near a stairway exit door, the alarm also gets triggered. E6, E14 and E15 stated that they were not aware of any alarms that went off during those times.

On March 2, 2016 at 4:00 pm, E16 (Receptionist) stated she did not hear the alarms on the front doors triggered. E16 stated that the alarms sound off when there is a resident with a monitoring device goes near the exit doors and that when the alarms sound, staff should check the exit areas for any residents who are at risk for elopement.

On March 3, 2016 at 2:00 pm. E2 (Director of Nursing) stated that when E1 and E2 interviewed E18 (Registered Nurse) during the investigation, E18 stated she heard an alarm on one of the exit doors, looked to see if someone was outside and when E18 did not find anyone, E18 deactivated the alarm.

On March 3, 2016 at 2:53 pm, E19 (Certified Nursing Assistant) E19 stated that on 12/31/15, E19 did not hear any alarms but stated that E19 thought that (E18) have heard and deactivated the alarm. E19 stated that when an exit door alarm is heard, staff looks to see on the first floor panel where the alarm is coming from and investigate whether there was a resident who went out or accidentally pushed the door. E19 stated that when it is clear, then the alarm can be deactivated.

On March 3, 2016 at 2:57 pm, E18 stated that E18 had heard an alarm from an outside exit door. E18 stated, "I had heard the alarm sound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

(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) COMPLETE DATE
S9999	Continued From page 10 off from the exit door leading to the outside of the facility. I had looked around to see if anybody was there but I did not see anyone. Since no one had announced (from the other floors) that they were missing a resident, and seeing that there was no one in the area where the alarm came from, I had turned off the alarm ...About 10-15 minutes later, I saw staff bring in (R1) from the outside." The facility's April 2013 policy on Missing residents and elopement document in part: Routine Procedures for the Prevention of Missing Residents and Elopements: -Close monitoring for elopement risk residents must be done on scheduled basis particularly at the beginning of each shift, during medication pass or at each meal and as often as necessary. The procedures for the response to missing residents and/or elopements shall be implemented for elopement risks residents who are not accounted for. -Facility personnel shall immediately respond to and determine the cause for the sounding of exit door alarms. If no reasons/causes can be identified, a specific missing resident alert code or announcement may be initiated as necessary. (A)	S9999		

IMPOSED PLAN OF CORRECTION

Grove of Evanston L & R
Complaint Survey 1690934/IL83506, exit date 3-3-2016

300.610a)
300.1210b)
300.1210d)6)
300.3240a)
300.2900d)2)

Attachment B
Imposed Plan of Correction

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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. Restorative measures shall include, at a minimum, the following procedures:

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:

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. (Section 2-107 of the Act)

Section 300.2900 General Building Requirements
d) Doors and Windows

2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

This will be accomplished by:

I. The facility will conduct an investigation of the incidents and take appropriate actions. The assessments for all residents identified as high risk for falls and/or elopement, and all residents requiring supervision will be reviewed for accuracy of the assessment and will be revised as necessary based on the outcome of the review. Care plans for those residents will be updated to include interventions to prevent injury and/or elopement. Policies and Procedures for Falls, and Policies and Procedures for Elopement will be reviewed and revised as necessary.

II. All staff will be in-serviced on Falls Policies and Procedures, as well as Elopement Policies and Procedures and any revisions made as a result of Item I. All staff will be in-serviced regarding the following:

- Identifying residents with potential for being affected by deficient practice (Falls Policy, Elopement Policy) by review of assessments, interventions, and updating of care plans. The facility will reflect condition/behavior changes, follow-up interventions, and reporting practices to physician(s) and family member(s) per facility policy;
- Systemic changes to reasonably assure deficiency does not recur by review of protocol for safety interventions, monitoring, care planning, and assessments;
- Monitor for compliance of assessment, intervention, and care planning per each occurrence as per occurrence;
- Quality Assurance (QA) tool with documentation and monitoring of compliance. All issues and concerns will be corrected immediately and reviewed during the monthly QA meeting.

III. Documentation of in-service training, assessments and related follow-up actions will be maintained by the facility.

IV. The Director of Nursing (DON) and/or Clinical Nurse Leaders, will audit documentation in the medical record for compliance weekly for six (6) weeks and then quarterly in the Quality Assurance meetings. Audits with negative outcomes will result in further education for staff involved and/or possible disciplinary action.

V. The Administrator and Director of Nurses will monitor Items I through III to ensure compliance with this Imposed Plan of Correction. The Administrator, Director of Nurses, and Quality Assurance Committee will monitor Items I through V to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Ten (10) days from receipt of this Imposed Plan of Correction.