STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145662	A. BUILDING _____ B. WING _____	C 08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN BRIDGE N & REHAB CENTRE	8333 WEST GOLF ROAD NILES, IL 60714

(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 1694175/ IL 87254--No deficiencies cited. 1694435/ IL 87542 - F323, F157, F280. Incident Investigation IRI of 8/7/16/IL 87541 - F323, F157, F280. IRI of 7/22/16/IL 87270--No deficiencies cited.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157		

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

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this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to notify the physician of several incidents of elopement on for 1 (R7) of 3 residents reviewed for physician notification, and failed to notify physician of verbalization of depression, hopeless, down feeling for 1 (R7) of 3 residents reviewed for change of condition.

Findings include:

R7 was admitted to the facility on 10/21/15 with the following diagnoses: Dementia with behavioral disturbances, encephalopathy, alcohol abuse with alcohol-induced disorder, COPD, muscle weakness and bilateral primary osteoarthritis of knees.

On 8/9/16 at 10:45am, E2 (Director of Nursing) stated that on 8/7/16 at approximately 8:30am, R7 was found unresponsive on the patio after R7 jumped out of his bedroom window. E3 was a resident on the locked dementia unit.

On 8/9/16 at 11:10am, E14 (Social Service) stated that R7 recently told him that he knows how to leave. E14 stated that R7 refused to talk about how he was going to leave.

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On 8/9/16 at 12:30pm, Z3 (Attending Physician) stated that R7 had asked her if he could go out on pass. Z3 stated that she talked to Z4 (Psychiatrist) and they both decided not to give R7 a pass. Z3 stated that R7 had former alcoholic syndrome. Z3 stated that R7 was the rebellion type. Z3 stated that on 7/23/16, R7 ran away from the nursing home. Z3 stated that R7 was brought back to the facility by the local police and put in the locked dementia unit. Z3 stated that R7 was angry that "we locked him up." Z3 stated that R7 was dangerous to himself. Z3 stated that R7 lived on impulses. Z3 stated that she thinks R7 was angry and that is why he jumped out of the window on 8/7/16.

On 8/10/16 at 2pm, Z4 (Psychiatrist) stated that R7 had dementia and mental illness from a head trauma. Z4 stated that R7 was not suicidal. Z4 stated that he thought that R7 probably thought he was going out and didn't realize that he was on the 5th floor when he jumped out of the window. Surveyor asked Z4 if this incident on 8/7/16 of R7 jumping out of his bedroom window could have been avoided. Z4 stated "Well, yes, the problem is that the facility should not have windows that can open enough to allow a resident to jump out of a window. That is the problem." On 8/11/16 at 10am, Z4 stated that he was not notified that R7 expressed feelings on depression, hopeless, down on 7/28/16. Z4 stated that if he was notified of R7's feeling of depression, hopeless or down, he would have talked to R7. Z4 stated that R7 always said he wanted to go home. Z4 stated that R7 was not clinically depressed.

R7's MDS (Minimum Data Set) dated 7/28/16

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reads under section D - R7 verbalized feelings of depression, hopeless or down- frequency "nearly every day for 12-14 days." On 8/10/16 at 2:30pm, E14 (Social Service) stated that he coded section D on R7's MDS on 7/28/16. E14 stated that R7 may have felt depressed, down, hopeless because he did not want to be on the locked dementia unit.

On 8/10/16 at 9am, E2 stated that the facility does not have incident reports for R7's incidents of elopement on 2/17/16, 3/10/16, 6/18/16 or 7/10/16. E2 stated that R7's physician was not notified after each incident.

R7's social service progress notes dated 2/17/16 read "R7 tried to escape the facility through the back door and alarm was activated by his motion. R7 was stopped at the parking lot by E14 and returned back to the facility. After that, E1 (Administrator) decided to transfer R7 to locked unit around 3pm but in 2 hours, R7 left the locked unit and returned to unlocked unit. R7 refused to return to locked unit." On 8/10/16 at 9am, E2 stated there is no incident report for R7's episode of elopement on 2/17/16 and R7's physician was not notified.

R7's social service notes dated 3/10/16 at 9:37 reads "Informed by E1 that around 8:30am on 3/9/16, R7 was missing. R7 was absent for more than 3 hours." On 8/10/16 at 9am, E2 stated that there is no incident report for R7's episode of elopement on 3/10/16 and R7's physician was not notified.

R7's social service notes dated 3/17/16 read "E14 was informed that R7 was standing by the

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F 157	Continued From page 4	F 157		

door, trying to go out. E14 stated that he wanted to walk around and get out away from the building. R7 stated per notes I don't want to be here anymore."

R7's nursing notes dated 6/28/16 at 00:00 read "R7 left facility without permission, was absent for about 30-40 minutes. Later found sitting on bus stop about a block away from facility- waiting for a bus to go home. R7 was escorted back to facility. Combative, verbally and physically abusive, makes threats against staff, swings arms trying to hit staff." On 8/10/16 at 1pm, E2 stated that there is no incident report for this incident and R7's physician was not notified.

On 8/9/16 at 12:30, E2 stated that R7 was found at local grocery store on 7/10/16 and brought back to the facility. On 8/2/16 at 9am, E2 stated that there is no incident report and the physician was not notified of this incident.

R7's nursing notes dated 7/23/16 at 01:46 read "R7 came back to facility, escorted by police. R7 alert, oriented x 3, uncooperative, agitated. E2 stated that R7 was transferred to locked dementia unit after the 7/23/16 episode of elopement.

R7's screening assessment indicators of aggression and harmful behavior dated 5/4/16 reads score is 3, minimal aggression risk, potential interaction with peers. On 8/9/16 at 2:45pm, E3 (Social Service Director) stated that there is no range of scores for this assessment.

R7's elopement/unauthorized departure risk assessment dated 3/10/16 reads score 12 (at risk- care plan recommended). On 8/9/16 at

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F 157	Continued From page 5 2:45pm, E3 stated that there is no range for scores for this assessment. R7 identified feelings of depression, hopeless, down for past 12-14 days identified by R7's MDS section D on 7/28/16. On 8/11/16 at 10:30am, Z4 (Psychiatrist) stated that he was not notified that R7 expressed feelings depression, hopeless, down on 7/28/16. Z4 stated that he would have talked to R7 if the facility had notified him regarding R7's feelings of depression, hopeless, down. Z4 stated that R7 always wanted to go home. The facility's notification of physician policy dated 3/07 reads "The attending physician or alternate physician is notified of changes in condition seven days a week, 24 hours a day, including holidays. Significant change in condition or status requires the physician's immediat input and treament for continued medical and nursing care. Examples:	F 157		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280		

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and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to follow the care plan policy and review/revise the plan of care with interventions to prevent or reduce the risk for elopement for 1 of 3 resident's (R7) all reviewed for elopement interventions

Findings include:

R7 was admitted to the facility on 10/21/15 with the following diagnoses: Dementia with behavioral disturbances, encephalopathy, alcohol abuse with alcohol-induced disorder, COPD, muscle weakness and bilateral primary osteoarthritis of knees.

On 8/9/16 at 10:45am, E2 (Director of Nursing) stated that on 8/7/16 at approximately 8:30am, R7 was found unresponsive on the patio after R7 jumped out of his bedroom window. E3 was a resident on the locked dementia unit.

On 8/9/16 at 11:10am, E14 (Social Service) stated that R7 recently told him that he knows how to leave. E14 stated that R7 refused to talk about how he was going to leave.

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On 8/9/16 at 12:30pm, Z3 (Attending Physician) stated that R7 had asked her if he could go out on pass. Z3 stated that she talked to Z4 (Psychiatrist) and they both decided not to give R7 a pass. Z3 stated that R7 had former alcoholic syndrome. Z3 stated that R7 was rebellion type. Z3 stated that on 7/23/16, R7 ran away from the nursing home. Z3 stated that R7 was brought back to the facility by the local police and put in the locked dementia unit. Z3 stated that R7 was angry that "we locked him up." Z3 stated that R7 was dangerous to himself. Z3 stated that R7 lived on impulses. Z3 stated that she thinks R7 was angry and that is why he jumped out of the window on 8/7/16.

The facility notes documented that R7 had 5 episodes of elopement on 2/17/16, 3/10/16, 6/28/16, 7/10/16 and 7/23/16. On 8/10/16 at 2:30pm, E14 stated that he did not update R7's care plan after each episode of R7's 5 elopement incidents.

R7's social service progress notes dated 2/17/16 read "R7 tried to escape the facility through the back door and alarm was activated by his motion. R7 was stopped at the parking lot by E14 and returned back to the facility. After that, E1 (Administrator) decided to transfer R7 to locked unit around 3pm but in 2 hours, R7 left the locked unit and returned to unlocked unit. R7 refused to return to locked unit." R7's care plan was not updated after R7's incident of elopement on 2/17/16.

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R7's social service notes dated 3/17/16 read "E14 was informed that R7 was standing by the door, trying to go out. E14 stated that he wanted to walk around and get out away from the building. R7 stated per notes I don't want to be here anymore."

R7's nursing notes dated 6/28/16 at 00:00 read "R7 left facility without permission, was absent for about 30-40 minutes. Later found sitting on bus stop about a block away from facility- waiting for a bus to go home. R7 was escorted back to facility. Combative, verbally and physically abusive, makes threats against staff, swings arms trying to hit staff." On 8/10/16 at 1pm, E2 stated that there is no incident report for this incident and R7's physician was not notified. On 8/10/16 at 2:30pm, E14 stated that he did not update the care plan after this elopement incident.

On 8/9/16 at 12:30, E2 stated that R7 was found at local grocery store on 7/10/16 and brought back to the facility. R7's care plan was not updated after R7's episode of elopement on 7/10/16.

R7's care plan initiated on 3/10/16 reads "R7 demonstrates movement behavior that may be interpreted as: attempts to unauthorized leave the facility related to diagnoses of alcohol induced dementia and problems understanding the immediate environment. Attempted to leave the unit or facility. 7/22/16. R7's care plan did not include updates for R7's elopement episodes on 2/17/16, 6/28/16 or 7/10/16.

The facility's care plan policy reads "Update care plan as needed to reflect current needs of the

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F 280	Continued From page 9 resident. When a new focus, outcome or intervention is identified, the entry should be dated using the date the focus/outcome/intervention is entered on the care plan."	F 280		
F 323 SS=G	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 interview and record review, the facility failed to develop and implement elopement risk intervention to monitor and provide supervision to prevent elopement of an at risk resident 1 of 3 resident R7 reviewed for elopement and wandering. This failure resulted in R7 exiting from the 5th floor window on the locked dementia unit and found on the patio bleeding and unresponsive and taken to the hospital where R7 was later pronounced dead. Findings include: R7 was admitted to the facility on 10/21/15 with the following diagnoses: Dementia with behavioral disturbances, encephalopathy, alcohol abuse with alcohol-induced disorder, COPD, muscle weakness and bilateral primary	F 323		

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osteoarthritis of knees.

On 8/9/16 at 10:45am, E2 (Director of Nursing) stated that on 8/7/16 at approximately 8:30am, R7 was found unresponsive on the patio after R7 jumped out of his bedroom window. E3 was a resident on the locked dementia unit.

On 8/9/16 at 11:10am, E14 (Social Service) stated that R7 recently told him that he knows how to leave. E14 stated that R7 refused to talk about how he was going to leave. R7's care plan dated 7/22/16 reads "Placed in alarmed unit for close monitoring." E14 stated that he would check on R7 daily but E14 noticed that there was a change in R7 within the past two weeks prior to his death. E14 stated that R7 did not want to be on the locked dementia unit and stated that he wanted to leave. R7's MDS (Minimum Data Set) dated 7/28/16 reads under section D - R7 verbalized feelings of depression, hopeless or down- frequency "nearly every day for 12-14 days." On 8/10/16 at 2:30pm, E14 (Social Service) stated that he coded section D on R7's MDS on 7/28/16. E14 stated that R7 may have felt depressed, down, hopeless because he did not want to be on the locked dementia unit.

On 8/9/16 at 12:30pm, Z3 (Attending Physician) stated that R7 had asked her if he could go out on pass. Z3 stated that she talked to Z4 (Psychiatrist) and they both decided not to give R7 a pass. Z3 stated that R7 had former alcoholic syndrome. Z3 stated that R7 was rebellion type. Z3 stated that on 7/23/16, R7 ran away from the nursing home. Z3 stated that R7 was brought back to the facility by the local police and put in the locked dementia unit. Z3 stated

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that R7 was angry that "we locked him up." Z3 stated that R7 was dangerous to himself. Z3 stated that R7 lived on impulses. Z3 stated that she thinks R7 was angry and that is why he jumped out of the window on 8/7/16.

On 8/10/16 at 2pm, Z4 (Psychiatrist) stated that R7 had dementia and mental illness from a head trauma. Z4 stated that R7 was not suicidal. Z4 stated that he thought that R7 probably thought he was going out and didn't realize that he was on the 5th floor when he jumped out of the window. Surveyor asked Z4 if this incident on 8/7/16 of R7 jumping out of his bedroom window could have been avoided. Z4 stated "Well, yes, the problem is that the facility should not have windows that can open enough to allow a resident to jump out of a window. That is the problem." On 8/11/16 at 10am, Z4 stated that he was not notified that R7 expressed feelings on depression, hopeless, down on 7/28/16. Z4 stated that if he was notified of R7's feeling of depression, hopeless or down, he would have talked to R7. Z4 stated that R7 always said he wanted to go home.

The facility notes documented that R7 had 5 episodes of elopement on 2/17/16, 3/10/16, 6/28/16, 7/10/16 and 7/23/16.

R7's social service progress notes dated 2/17/16 read "R7 tried to escape the facility through the back door and alarm was activated by his motion. R7 was stopped at the parking lot by E14 and returned back to the facility. After that, E1 (Administrator) decided to transfer R7 to locked unit around 3pm but in 2 hours, R7 left the locked

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unit and returned to unlocked unit. R7 refused to return to locked unit."

R7's social service notes dated 3/10/16 at 9:37 reads "Informed by E1 that around 8:30am on 3/9/16, R7 was missing. R7 was absent for more than 3 hours."

R7's social service notes dated 3/17/16 read "E14 was informed that R7 was standing by the door, trying to go out. E14 stated that he wanted to walk around and get out away from the building. R7 stated per notes I don't want to be her anymore."

R7's nursing notes dated 6/28/16 at 00:00 read "R7 left facility without permission, was absent for about 30-40 minutes. Later found sitting on bus stop about a block away from facility- waiting for a bus to go home. R7 was escorted back to facility. Combative, verbally and physically abusive, makes threats against staff, swings arms trying to hit staff."

On 8/9/16 at 12:30, E2 stated that R7 was found at local grocery store on 7/10/16 and brought back to the facility.

R7's nursing notes dated 7/23/16 at 01:46 read "R7 came back to facility, escorted by police. R7 alert, oriented x 3, uncooperative, agitated. E2 stated that R7 was transferred to locked dementia unit after the 7/23/16 episode of elopement.

R7's screening assessment indicators of aggression and harmful behavior dated 5/4/16 reads score is 3, minimal aggression risk, potential interaction with peers. On 8/9/16 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145662	A. BUILDING _____ B. WING _____	C 08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN BRIDGE N & REHAB CENTRE	8333 WEST GOLF ROAD NILES, IL 60714

(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 13 2:45pm, E3 (Social Service Director) stated that there is no range of scores for this assessment. R7's elopement/unauthorized departure risk assessment dated 3/10/16 reads score 12 (at risk- care plan recommended). On 8/9/16 at 2:45pm, E3 stated that there is no range for scores for this assessment. The facility's accident/incident report dated 8/7/16 at 8:35am reads "Notified by staff member that R7 had fallen, ran down to patio and observed R7 lying on the ground not responsive and bleeding. 911 called. Paramedics on the scene. Police arrived."	F 323		