Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008692	A. BUILDING: _____ B. WING _____	03/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANISH HOME, THE	5656 NORTH NEWCASTLE AVENUE CHICAGO, IL 60631

(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
Z 000	COMMENTS Complaint Investigation 1581287/ IL75606	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	Z9999	**Attachment A** **Statement of Licensure Violations**	

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and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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:

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 300.1220 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,

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Z9999	Continued From page 2 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 requirements are not met as evidenced by: Based on interview and record review, the facility failed to update care plan to reflect noncompliance with alarm bracelet and need for increased supervision to prevent elopement for one(R1) of three residents reviewed for elopement; failed to provide adequate supervision for one (R1)resident of three residents reviewed with dementia. This failure resulted in R1 eloping from the facility on 2/7/14 in subzero temperatures while inadequately dressed. Findings include: Facility's last Annual Licensure was on 10/16/14. State of Illinois Department of Public Health License is for both Skilled and Sheltered Care and expires 12/31/16. R1 resided in a skilled care bed (room 135) on date she eloped according to nursing notes. On 3/26/15 at 9:30 am Z1(Police Officer in charge of community relations) indicated there was only one call in last 2 years for an elopement from the facility and that was (R1). R1 is no longer in the facility but according to police report of 2/7/14 EV#03696, " officer	Z9999		

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Z9999	Continued From page 3 responded to call of a missing person of tender age from (the facility). Missing is (R1) female age 72 ...Missing wearing a pink, white and gray shirt, gray pants, no jacket and suffers from dementia. Missing walked out of home approximately 0830 am. R1 was found by neighbors who took her to the police station. R1 was then transported to the hospital. Police report notes approximate time of exposure is 10 to 15 minutes. On the report E1 (president and Chief Executive officer of the facility) is quoted as saying, " (alarm bracelet) should have been on (R1) and was not, which affects staff. " On 3/26/15 at 10:00 am E1 stated, " She (R1) was sent to another facility. She left the dining room on ground floor. Took elevator to lobby and walked out. It was subzero temperature. She was safe fast. She has Alzheimer dementia. About 45 minutes later police called and said they had her. Moved out 2 weeks later. In her case did not have (alarm bracelet) because she wasn ' t risk to wander away. Did not report as not required because no injury. " On 3/26/15 at 2:00 pm E2(Director of Nursing) stated, "I was her(R1) nurse at time she left. E3(Certified Nursing Assistant/ C.N.A.) was her C.N.A. E3(C.N.A) took her down to breakfast. E4(Dietary Manager) knows that (R1) not to leave building by self. She took (alarm) bracelet off. Z4(companion for R1) found it in room. Companion starts at 10:00 am. More then 2 years did not wander off. She was elopement risk. Taking off (alarm bracelet) increases risk of elopement. When left through door had camera video. Cameras are kept in nursing station, front desk and in (E5) office. No one always looking at camera. (Her) care plan does not say what to do if bracelet off. (Z3, former Director of Nursing) was responsible for care plan during time (R1 eloped). She was right by nursing station. She	Z9999		

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was cutting it or forcing it out of hand. We didn't chart that (R1) was taking it off. She was supposed to have alarm bracelet on when she left. Supposed to do visual. In December started cutting and forcing (alarm bracelet) off. 8:35 am not in dining room. 911 called around 9:00 am. 9:13 received call from Police."
On 3/27/15 at 9:50 pm E6(Registered Nurse) stated, "Since 2011 I've been working with her. Only work part-time. It was a lot of times she cut it(alarm bracelet) off." I told Z3(former Director of Nursing). On 3/26/15 at 3:50 pm Z5(Attending Physician for R1) stated, "Moderately confused. Anxious, agitated, always worried. Hindsight is 20/20. Demonstrate behavior and don't have locked unit. Should have been transferred. I wasn't aware she was taking it(alarm bracelet) off. Then we have to figure out some other solution. Would have said we need to find placement."
On 3/26/15 at 4:00 pm Z2(Guardian of R1) stated, "She left from Hotel. She was independent living(before admitted to facility). Flourished but eventually more and more confused. One day (while at hotel) went out. Police had to bring her back twice. She did well(at facility). One day wandered out. I knew taking off (alarm bracelet). I hoped they were monitoring her. They didn't watch her enough. Giving her too much credit or not enough. Moderate dementia. Safety risk."
Incident report of 2/7/14 notes R1 was sent to the emergency room after the elopement with "no frostbites to any extremities."
Requested care plan in place immediately prior to R1 elopement. Received care plan dated 2/14/13 in which R1 is described as elopement risk and approach was to issue a bracelet alarm. After 2/14/13 there are no updated care plans acknowledging R1' s issue with taking off the

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Z9999	Continued From page 5 alarm bracelet and what approaches to take. After she elopes there is an additional elopement care plan put in place dated 2/7/14, the same day as R1 eloped. This care plan initiates hourly rounding and that alarm bracelet be checked during change of shift and through out shift. On 3/27/15 at 1:30 pm E2(DON) stated, " on admission there ' s comprehensive assessment. (Z5) Attending physician for (R1) does a yearly complete History and Physical. Only one done is 12/19/11. Changes are noted in nursing notes. No documentation take off (alarm bracelet). Just one note refused. Don ' t find documentation what to do if takes off bracelet but should have kept on all time. Care plan not reviewed and modified with her taking off bracelet. It focused more on agitation and anxiety. Care plan should be reviewed every 3 months. (Z3) former Director of Nursing was in charge of care plans. " Facility could not locate policy and procedure in place for elopement at the time E1 eloped. Revised policy dated 3/3/14 states, "any at risk resident who is not compliant in wearing the the (alarm bracelet) device will be discharged from the community." (B)	Z9999		