STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014856	A. BUILDING: _____ B. WING _____	C 06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT WINDSOR PARK	2649 EAST 75TH ST CHICAGO, IL 60649

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S 000	Initial Comments Complaint Investigations: 1984430/IL113182 - F689(J)	S 000		
S9999	Final Observations Statement of Licensure Violation. 300.610 a) 300.1210 a) 300.1210 b) 300.1210 d)6) 300.3120 a) 300.3240 a) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental 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 300.3120 Mechanical Systems

a) Mechanical systems shall be maintained to assure proper working order and safe

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S9999	Continued From page 2	S9999		

operation. Instructions in the operational use of the systems and equipment shall be available at the facility.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations were not met as evidenced by:

Based on observation, record review, and interview the facility failed to monitor and supervise a cognitively impaired resident (R1) by not implementing the facility's practice for monitoring residents every two hours and not having a functioning monitor alarm system in place to alert staff when a resident with a wandering behavior attempted to leave the building.

As a result, a cognitively impaired resident (R1) with a known behavior of wandering exited out the facility without the staff alerted until R1's absence was noted. R1's whereabouts were unknown by the facility staff putting the resident at risk for possible harm. R1 was found 6 days after R1's elopement by family members.

This deficient practice relates to 4 of 4 residents (R1, R2, R3, and R5) who were reviewed for elopement risk, in a sample of 11 residents.

Findings include:

Face sheet documents R1 is a 70 year old admitted to the facility on 05/31/19 with the diagnosis
of the following: traumatic ischemia of muscle,

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S9999	Continued From page 3	S9999		

syncope (fainting), acute kidney failure, schizophrenia, atrial fibrillation, generalized muscle weakness, stroke, traumatic brain injury, high blood pressure, and dementia.

R1's Minimum Data Set (MDS) dated 06/13/19 documents R1 has moderate cognitive impairment.

Care plan date 05/31/19, notes R1 displays movement behavior and may be an elopement risk/wanderer. Interventions identified include: secured unit, staff aware of R1's wander risk, and mechanical monitoring device. According to facility's room roster, R1 resided on the 3rd floor of the facility, which was identified as a locked or monitored unit.

R1's Elopement Risk Review dated 05/31/19 documents R1 is at risk for elopement.

The facility's incident report dated 06/20/19 documents on 06/18/19 staff observed R1 not in facility during shift. R1 was unable to be located. Investigation initiated, physician notified, police notified.

On 06/20/19 12:40pm, V21, (family member) stated V2 DON (director of nursing) informed V21 this facility does not lock any residents down. V21 stated R1 has a history of wandering when R1 resided at home. V21 stated the liaison for this facility was informed of R1's wandering history while R1 was still in hospital, prior to admission to facility. The liaison assured V21 that R1 would be placed on a secured unit for R1's safety. V21 stated V21 and V22 (family member) visited with R1 on the afternoon of 6/18/19 when they attended a care plan conference. V21 stated R1's history of wandering was discussed

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S9999	Continued From page 4	S9999		

at this meeting. V21 stated when R1 wandered off at home, R1 could find way back home sometimes. Most of time, R1 would become confused and was not able to find way home. At the time of the interview, V21 stated R1 still remained at large.

On 06/25/19 11:25am V21 (family member) reported V21 was told by the local police R1 walked to the emergency room (ER) at a local hospital on 06/20/19. R1 was not able to tell ER staff R1's address, so a community organization was notified, picked R1 up and brought him to a mission. R1 walked out of the mission the same day. R1 went to another local hospital at 3:00pm on 06/23/19 and was discharged from the emergency room at 7:00pm on his own. V21 stated family members found R1 on 6/24/19 at 8:00pm, standing in the middle a high traffic street.

On 06/20/19 at 11:50am, V3 CNA (certified nurse aide) stated V3 worked 7am-3pm on 6/18/19. V3 stated R1 walks the unit all day. V3 stated R1 is alert and oriented to person and place. V3 stated there is an alarm in the elevator that will sound if a resident with a mechanical monitoring device gets into the elevator. V3 stated this alarm is silent on the nursing unit, so the resident does not become scared of the alarm. V3 stated the alarm sounds at the first floor nursing unit to alert staff the resident is in the elevator. V3 stated that V3 rounds on assigned residents every two hours. V3 stated staff check for mechanical device placement on residents once a shift.

On 06/20/19 at 12:15pm, V2 DON (director of nursing) stated the elevator alarm is supposed to alarm on each nursing unit. V2 denied this is a silent alarm. V2 stated the maintenance director

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VILLA AT WINDSOR PARK	2649 EAST 75TH ST CHICAGO, IL 60649

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S9999	Continued From page 5	S9999		

is responsible for checking all door alarms and elevator alarms daily to ensure functioning properly. V2 stated social service staff are responsible for checking the mechanical monitoring devices to ensure the battery has not expired and to ensure these devices alarm when activated; this is done weekly. V2 stated staff are responsible for checking the placement of the mechanical monitoring device every shift. This surveyor observed during this same time,V2 with a mechanical monitoring device enter the elevator on the third floor nursing unit and exit elevator in basement; the device did not alarm at any time. V2 proceeded through a basement door leading to the stairwell. The exit door to the parking lot alarm sounded when the door was opened but did not alarm when mechanical monitoring device was near door. V2 and this surveyor proceeded onto the first floor nursing unit and the exit door alarm was not audible at the nurses' station. V2 stated the alarm in the elevator is supposed to sound when a resident with a mechanical monitoring device is near elevator door. The alarm is not supposed to stop sounding until the resident is away from the elevator.

On 06/20/19 while with V2, the surveyor noted the facility's first floor has a main entrance/exit door on the northside of the building, one exit door on the east side of the building (leading to the parking lot), an exit door on the west side of the building, and one exit door on the south side of the building.

On 06/20/19 at 4:10pm, V4 LPN (licensed practical nurse) stated V4 was working 3-11:30pm shift on the first floor nursing unit on 06/18/19. V4 stated V4 was in a resident's room near the stairwell providing care when V4 heard the stairwell alarm. V4 stated this alarm was

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S9999	Continued From page 6	S9999		

faint; if V4 had not been near the exit V4 would not have heard the alarm. V4 stated V4 entered the code to de-activate the door alarm and checked the stairwell for any residents or staff. V4 stated V4 did not see anyone. V4 stated the exit door to the parking lot was also alarming. V4 stated the door would not open due to the alarm and V4 did not know the code to de-activate the alarm. V4 stated V4 went to the main entrance and got security staff to assist with de-activating the alarm. V4 stated this occurred about 10:00pm. V4 looked through a window (10 inches x 10 inches) on the exit door and did not see anybody outside. V4 stated V4 was not aware R1 was missing until the alert for a missing resident was paged overhead after 11:00pm. V4 stated V4 rounds on residents every two hours.

On 06/20/19 at 4:20pm, V6 CNA stated V6 worked 3-11pm shift on the third floor nursing unit on 06/18/19. V6 stated V6 rounds on residents every two hours. V6 stated the last time V6 saw R1 was when V6 gave R1 dinner tray. V6 stated R1 is ambulatory and wanders on the unit.

On 06/20/19 at 4:26pm, V8 CNA stated V8 worked 3-11pm shift on the third floor nursing unit on 06/18/19. V8 stated V8 rounds on residents every two hours. V8 stated the last time V8 saw R1 was in the dining room at dinnertime. V8 stated R1 is ambulatory and wanders on the unit.

On 06/20/19 at 4:30pm, V9 CNA stated V9 worked 3-11pm shift on the third floor nursing unit on 06/18/19. V9 stated V9 rounds on residents (assigned from rooms 319 and 324 west hallway) every two hours. V9 stated the last time V9 saw R1 was in dining room at dinner time. V9 stated R1 is ambulatory and wanders on the unit.

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S9999	Continued From page 7	S9999		

On 06/20/19 at 4:35pm, V10 CNA stated V10 worked 7am to 10pm on the third floor nursing unit on 06/18/19. V10 stated V10 rounds on residents every two hours. V10 stated the last time V10 saw R1 was in the dining room at dinnertime. V10 stated R1 is ambulatory and wanders on the unit.

None of the CNAs (certified nurse aides) who were on duty 06/18/19 and could be interviewed were able to account for the R1's presence on the unit. The aide assigned to R1 that night was unavailable for an interview at the time of the survey.

On 06/21/19 at 1:12pm, V20 LPN stated V20 worked 3-11:30pm shift on 06/18/19 and was assigned to provide care for R1. V20 stated V20 brought R1 medications at 5:30pm while R1 was in dining room. V20 stated R1 approached V20 at medication cart 15 minutes later requesting medications. V20 stated V20 informed R1 that R1 just took medications. V20 stated R1 had an angry expression on R1's face. V20 stated R1 appeared to be upset but was not able to verbalize what was wrong. V20 stated that was the last time V20 saw resident that evening. V20 denied any increased monitoring was initiated or that V20 investigated R1's mood further. R1 went back to sit in dining room for dinner. V20 stated V20 administered R1's scheduled 9:00pm medications at 5:30pm because R1 can become aggressive if R1 is woken up from sleep for medications. V20 stated V20 does not round on residents, CNAs are responsible for rounding on residents. V20 stated at 10:00pm, V20 was informed R1 was not in R1's room. V20 stated staff searched all rooms and V20 notified V19 (supervisor).

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VILLA AT WINDSOR PARK	2649 EAST 75TH ST CHICAGO, IL 60649

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S9999	Continued From page 8	S9999		

This facility's wandering and elopement guideline policy, dated 03/16/17 notes "upon admission, residents will be evaluated for potential elopement risk. Information will be obtained from representatives, observation, and social history. At any time during a resident stay there may present indication of an elopement risk. It is the responsibility of staff to remain with the resident until a licensed nurse conducts an evaluation. The interdisciplinary team will meet with family and determine appropriate continued interventions and modify the care plan as needed. Residents identified at risk will have a mechanical monitoring device placed. Door security codes will be shared with staff members only. Security codes will not be shared with the resident representatives or residents. It is the responsibility of the staff to enter security codes to support visitors exiting the unit. Door alarm function will be checked daily by maintenance personnel. Maintenance is responsible for checking the resident transmitter to make sure door stays locked and alarm sounds when mechanical monitoring device is near elevator/door."

On 06/20/19 at 12:00pm, this surveyor asked staff on the third floor nursing unit to enter the code for the elevator for this surveyor. Staff sitting at nurses' station, 20 feet away, verbalized the code to this surveyor so this surveyor could enter code. No staff member approached the elevator to enter elevator code.

On 6/20/19 at 1:30pm, V1 administrator stated on 06/19/19 V1 interviewed V23 (maintenance director) regarding this facility's elevator and door alarms. V23 informed V1 that V23 had not checked the alarms for a long time but documented on the log sheets that checks had

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S9999	Continued From page 9	S9999		

been done. V1 stated the alarms in the elevator were installed in January and V1 believed alarms were functioning properly.

This surveyor observed on 06/20/19 that a mechanical monitoring device was attached to the ankles of R2, R3, and R5. According to R2, R3, and R5 physicians' orders for June 2019, R2, R3, and R5 do not have physicians' orders that allows them to leave the facility independently.

R2's quarterly assessment 05/8/19 indicated R2 had moderate cognitive impairment and wandering behavior present. While present on the third floor unit 06/20/19 R2 exhibited wandering throughout the secured unit.

R3's quarterly assessment 06/1/19 indicated R3 had cognitive impairment. According to the wanderer/elopement risk assessment dated 1/11/19, R3 was at risk for elopement. While present on the third floor unit 06/25/19, R3 exhibited wandering throughout the secured unit.

R5 was newly admitted on 06/18/19 to this facility. R5 is alert and oriented x 1. While present on the third floor unit 06/25/19, R5 exhibited wandering throughout the secured unit

(A)