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	146024	A. BUILDING _____ B. WING _____	C 8/23/04

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA GARDEN & REHAB CTR	**1008 EAST BROADWAY ASTORIA, IL 61501**

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F9999	FINAL OBSERVATIONS	F9999		

Surveyor: 13886

STATE LICENSURE FINDINGS:

300.510e) The licensee and the administrator shall be familiar with this Part (Section 300.510). They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities.

300.1210a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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.

300.1210b)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.

300.3100d)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

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F9999	Continued From page 23 signal is not required. These REGULATIONS are not met as evidenced by: Based on observation, interview, and record review, the facility failed to monitor 1 of 1 newly admitted, confused residents who was making comments regarding wanting to go home. Facility staff failed to share information with other key staff regarding R1's overt actions to leave the facility. The facility failed to have a system in place to monitor the front exit door. The alarm on the front exit door was set on "chime" rather than "alarm". R1 left the facility unnoticed and was found approximately 1/10 of a mile away from the facility, across busy State Route 24 sitting on the curb after dark. Findings include: R1's current physician order sheet dated 8-3-04 identifies R1 as a 93 year old man with diagnoses including Alzheimer's disease, anxiety, depression, hypertension, congestive heart failure, and lung cancer. Nursing notes dated 8-3-04 state R1 was admitted at 1:00 p.m. from home. This note describes R1 as "alert yet confused and wandering halls." Nursing note for 8-3-04 at 5:00 p.m. states R1 "confused/disoriented". A note timed at 7:00 p.m. that day states R1 was "wandering in hallways - gait steady - talking about going home but did not try to exit facility..." This note was signed by the charge nurse on duty, E6. Nursing note dated 8-3-04 at 8:30 p.m. states "unable to locate resident in building - found that he had exited the facility and was outside - did not	F9999		

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F9999	Continued From page 24 want to re-enter building and refused for quite awhile..." During interview on 8-10-04 at 2:30 p.m., E6 stated she was the charge nurse on duty 8-3-04 when R1 left the building. E6 stated she came on duty at 5:00 p.m. that evening. E6 stated she had no indication that R1 wanted to leave the facility before his elopement. During interview with E10, CNA, on 8-11-04 at 9:45 a.m., conflicting information regarding E6's lack of knowledge was received. E10 confirmed she was working the evening of 8-3-04 when R1 eloped. E10 stated R1 wandered around a lot and seemed anxious and irritable. E10 stated between 4:30 and 5:00 p.m., she was taking R1's blood pressure when R1 stated he "wanted to go back home." E10 stated she informed her charge nurse, E6, of R1's statement. During interview on 8-9-04 at 12:00 p.m., E3, Care Plan Coordinator, stated she was working the day R1 was admitted to the nursing home. E3 stated she heard R1 offering people money to take him back to his home town that day. E3 did not indicate that this information was passed on to other employees. During interview on 8-9-04 at 9:45 a.m., E1, Director of Nursing, was questioned about R1's elopement on 8-3-04. E1 stated that on the evening of 8-3-04, she received a phone call at home from E6, the Charge Nurse on duty, stating that R1 was outside the nursing home and then later that it had taken 45 minutes to get him to come back in the facility. E1 stated no one saw R1 leave the building. E1 stated when R1 couldn't	F9999		

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F9999	Continued From page 25 be found in the facility, staff looked outside and found R1 in the "parking lot road." E1 was unsure exactly where R1 was found or who found him. E6 related the following: When she started the medication pass at 8:00 p.m., R1 was sitting near the nurses desk. At 8:30 p.m. several CNAs (Certified Nursing Assistants) on duty told her they could not locate R1. E6 instructed them to re-search inside the facility then sent E8 (CNA) and the E16 (Activity Director) out to search the perimeter. E6 made a few phone calls and then was alerted by one of the staff that R1 had been found. E6 did not know who had found R1 but stated R1 had been found at the end of the parking lot spaces located on the north lane which leads out to US Route 24. E6 went outside and down the walkway to the edge of the lane to help convince R1 to re-enter the facility. During interview on 8-18-04 at 9:45 a.m., E6 stated she knew how R1 got out that night. E6 stated the front door was set on chime and should have had the loud alarm on. She stated the facility has a lot of visitors, so the front door alarm chimed a lot during that time. E6 stated that she only knew she had a "new resident." She further stated she received no oral report from the admitting nurse who went home before the elopement occurred. E6 confirmed her earlier statement that no one reported to her that R1 mentioned wanting to leave the facility even though her nursing note dated 7:00 p.m. that evening said "...talking about going home..." and E10 stated during interview that she told E6 that R1 stated he "wanted to go back home." During interview on 8-9-04 at 1:30 p.m., E8 stated	F9999		

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F9999	Continued From page 26 she worked the evening of 8-3-04 and that R1 was a new resident to the facility. E8 stated R1 had been pacing earlier in the evening but did not know he was an elopement risk. E8 stated about 8:30 p.m., E6 informed E8 that R1 was missing. E8 searched the building then grabbed a flashlight and went "out back and came around front and found resident looking at the grass and bushes in the parking lot." E8 stated R1 was confused when found and that she brought him up to the bench at the end of the walkway to the facility. E2 and E4 (day nurse) came out and stayed with R1 and E8 went inside. E8 stated she was alone when she found R1. E8 stated it was dark outside but she could see by the outside lights of the nursing home. E8 took this surveyor to spot where she said she found R1 which was next to the last northern parking space in the parking lot located on the lane leading from the facility out to Route 24. During interview on 8-10-04 at 9:14 a.m., E2, Social Service Director/Assistance Administrator, stated on the evening of 8-3-04 E1 called her and stated that the staff were having trouble with R1. E2 went to the nursing home and when she arrived, E8 was with R1 who was sitting on the bench at the far end of the walkway leading to the nursing home front door. E2 was not sure what time this occurred but stated it took 45 minutes to get R1 back into the facility. During confidential interview on 8-17-04 at 1:00 p.m., surveyors were told that E6 instructed interviewee to say that R1 was found "in the parking lot" even though interviewee witnessed R1 off facility grounds on US Route 24.	F9999		

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F9999	Continued From page 27 During confidential interview on 8-17-04 at 1:10 p.m., surveyor was told that on the night R1 eloped, interviewee was called at home after work by "supervisory staff" and was told that if anyone asked to "say R1 was found on the front lawn or parking lot." Interviews with community persons yielded conflicting information with the facility staff's account of the elopement. During interview on 8-10-04 at 10:20 a.m., Z1 stated that on 8-3-04 about 8:30 p.m., he and a friend came into town on Route 24 and saw an old man sitting on the curb on the north side of the street with his feet in the road (Route 24). Z1 indicated it was dark at that time. About 15 minutes later they came back and a Sports Utility Vehicle with its flashers on was parked there and 2 nursing home employees (identified as wearing "smocks" like nursing home workers wear) were present. Z1 stated the man he had seen earlier was being escorted in an easterly direction back towards the nursing home. Z1 stated he left and informed an acquaintance, Z2, of the incident. Z1 was able to identify R1 by name. During interview on 8-11-04 at 10:25 a.m., Z2 stated that on 8-3-04 Z1 informed him of an older man found on Route 24 near the nursing home being escorted back towards the home. Z2 stated he then went to the nursing home and upon arrival saw R1, whom he identified by his first name, sitting in a vehicle belonging to E8 parked in front of the nursing facility. Z2 stated 3 nursing home employees, whom he identified as E8, E2, and the other unknown to him, were with R1. Z2 stated R1 had a fly swatter in his hands and seemed upset about being confined in the vehicle.	F9999		

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F9999	Continued From page 28 During interview on 8-16-04 at 11:10 a.m., Z6 stated a while back on a Monday or Tuesday night around 8:30 or 9:00 p.m., Z6 was driving down Broadway Street (the same as US Route 24) and noticed an elderly white male sitting on the curb on the north side of the street with a fly swatter in his hand. Z6 stated the individual was right in the roadway. R6 related traffic was "constant" at that time. Z6 wondered if the man was from the nursing home but thought "how would he get out of the nursing home?" Z6 was passing the individual for the second time and was preparing to stop to assist because of the danger of the man being in the road when Z6 saw a maroon van with people in "scrubs" getting out to help the individual. During interview on 8-16-04 at 10:45 a.m., Z7 stated last week about 9:00 to 9:30 p.m., a women came to the door saying there was an elderly man sitting on the road curb in front of Z7's house. This location is one tenth of a mile from the nursing home on the opposite side of Broadway Street (US Route 24) one block west of where the speed limit changes from 45 miles per hour to 35 miles per hour heading west and where it changes from 35 miles per hour to 45 miles per hour heading east. The woman was concerned the individual would get hit by a car. Z7 related it was dark outside at that time. Z7 stated traffic on Broadway Street is heavy during the daytime and a little lighter at night. Z7 stated his wife called the nursing home and informed a female worker about the man sitting on the curb. On 8-11-04 at 9:40 a.m., Z3, a relative who brought R1 to the nursing home, was interviewed. When asked if Z3 had told the facility that R1 might want to leave, Z3 declined to answer. When surveyor	F9999		

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F9999	Continued From page 29 stated that R1 had eloped from the facility on 8-3-04, Z3 stated "that's nothing new." Review of nursing notes dated 8-4-04 at 12:00 p.m., "family notified of unwitnessed exit. States "that's what he does." During interview on 8-10-04 at 10:30 a.m., E1 stated the front main door entrance to the nursing home is now alarmed with a key punch alarm that sounds within seconds of opening the door unless a code is punched into a key pad located on the door to disarm the alarm. E1 stated this alarm system can be switched from delayed alarm to instant alarm, chime mode, or off. Before R1 was admitted, the alarm was positioned on the chime mode which would sound a slow "ding-dong" instead of a loud alarm. E1 stated staff had been known to switch the chime mode to alarm mode if they had a resident at risk for elopement. However no one was assessed at risk for immediate elopement right before R1's admission, so the alarm system that day was set on chime mode. This information was verified with E6, E16, and E8 during their above interviews. During interview on 8-18-04 at 11:40 a.m., E1 stated they have many visitors who come and go through the front door during the day and evening hours. On 8-9-04 at 9:45 a.m., R1 was observed up ambulating independently near nurses station and front lobby area. At 2:30 p.m. that afternoon, R1 was observed in his room looking at scraps of paper on a table. When asked what his name was, R1 stared off is space, muttered, and then stated his last name. R1 proceeded to talk at length without making any sense. When asked safety questions as in what to do before crossing the street, R1 could not answer. R1 was observed	F9999		

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F9999	Continued From page 30 again on 8-10-04 at 9:50 a.m., ambulating slowly about room with his head down looking at his feet. R1 still could not answer questions intelligently. Based on observation, record review, and interview, the facility failed to have an effective administrative system in place. Facility administrative staff failed to thoroughly investigate the circumstances of a newly admitted resident's elopement (R1). Supervisory staff instructed direct care staff to provide false information during the Department's investigation of the elopement. The failure to thoroughly investigate and obtain factual information regarding the elopement placed confused residents at risk for further elopement and possible harm when unsupervised (R1, R2, R3). Facility administrative staff failed to demonstrate a clear, working knowledge of their management positions. The facility failed to have adequate staffing to allow Administrative personnel to effectively manage direct care staff. This lack of staff management potentially places all residents at risk for improper nursing care, lack of supervision, and abuse. Findings include: 1. According to nurse notes dated 8-3-04 at 1 p.m., R1 was admitted to the facility at 1 p.m. and was found missing from the facility at 8:30 p.m. that same night. During interviews on 8-9-04, 8-10-04, and 8-18-04 with E1, Director of Nursing, and E6, Charge Nurse on duty that evening, it was verified that R1 had left the facility unattended and unnoticed by staff. Both of these Administrative personnel stated that no	F9999		

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F9999	Continued From page 31 investigation of this elopement had been conducted at the time of survey. E1 during interview on 8-9-04 at 9:45 a.m. provided a form with limited information regarding the elopement as the only investigation done. According to E1, she received information from E6 and did not interview anyone else about the incident. E1 could not provide any information as to where the resident was found, while E6 stated that the resident had been found at the end of the parking lot. E1 stated she did not come to the nursing home to start an investigation that evening nor did she instruct the nurse on duty or anyone else to start an investigation. During interview on 8-16-04 at 11:35 a.m., E1 again stated that she did no other investigation and spoke with no other staff regarding the incident. E1 stated, "I'm sure I don't have all the facts. I did not know." During interview on 8-18-04 at 9:45 a.m. with E6, when E6 was asked if she had started an investigation into the incident, E6 stated she had not handled an unwitnessed exit before and "didn't know what to do". E6 again verified that she did not question the CNA's working that night about who found R1 or any other details relating to his unwitnessed exit. E6 verified that she did not make out any report other than charting in the nursing notes what E1 instructed her to chart. Information gained from community resources and confidential interviews provided a much different scenario than the information provided by these Administrative staff regarding the elopement incident. Confidential interviews also showed that E6 instructed the interviewee to say that R1 was "found in the parking lot", even though the resident was witnessed off facility grounds across a busy	F9999		

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F9999	Continued From page 32	F9999		

state highway. These confidential interviews also showed that "supervisory staff" called persons at home instructing them "if any one asked , say (R1) was found on the front lawn or parking lot".

2. During interview with E1 on 8-18-04 at 11:40 a.m. regarding her job duties, E1 related that currently she is the Director of Nursing. E1 stated that in addition to being the Director of Nursing, she acts as Administrator when the Administrator is not in the building. During the course of the survey, the Administrator was not in the building except for the day of the exit. According to this interview, the Administrator generally is in the facility Tuesday through Friday.

E1 was asked regarding who was the Abuse Coordinator. E1 replied that she was not sure, but thought she must be, stating that she would be the one doing any investigation and reporting it to the Department. E1 was asked to provide policies and procedures related to abuse and neglect. A book of policy and procedures was provided, however it did not contain any policy related to abuse. After some time, a second book was located which had a policy for "Reporting/investigating resident abuse" and "Preventing Abuse and/or Neglect".

In reviewing the policy for "reporting/investigating resident abuse" it was found that the policy is not in compliance with Federal regulations which require that "the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported...". This policy includes statement that "should the investigation reveal that there is

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F9999	Continued From page 33 credible evidence that abuse, neglect, or misappropriation occurred, the Administrator or his/her designee will report such finding to the appropriate agency including, where appropriate, the local police department, the Ombudsman and the state licensing agency, within 24 hours of receiving the final result of the completed investigation. Credible evidence exists when the investigation leads a reasonable person to conclude that it is more probably true than not that the abuse occurred." E1 also stated that she routinely passes medications to one of the two wings of the nursing home Monday through Friday, as well as doing all telephone orders for the residents, reviews all medication administration records, tracks all psychotropic medications, and during the month of July this Director of Nursing covered the vacation schedule for the charge nurse, working the night shift as Charge Nurse and staying over during the day to be the Director of Nursing. When questioned regarding doing the review of the medication administration records and tracking psychotropic medication orders, E1 stated that she had told the 3rd shift nursing staff to do this, but they had refused saying they were "too busy". E1 was also asked about R1's telephone order dated 8-4-04 for Ativan 0.5 milligrams one to two tabs every hour PRN (as needed) for agitation/restlessness" . According to interpretive guidelines of the Federal regulations, 2 milligrams of Ativan is the daily dose. Daily dose is defined as "doses...for geriatric or elderly residents", with the facility being able to increase the dose if evidence shown that it is necessary. As written,	F9999		

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F9999	Continued From page 34	F9999		

this order potentially allows facility staff to administer up to 24 milligrams Ativan daily. Although E1 stated that she does the telephone orders, she was not aware of the current order on R1's chart.

On the day of interview 8-18-04, E1 also stated that E3, Care Plan Coordinator, would be off starting 8-19-04 on a four to six week medical leave. During this time, the DON would be picking up the additional duties of Care Plan Coordinator, making her responsible for the overall MDS review and care plans for the 46 residents in the facility. The overall care needs of the resident are based on accurate and timely MDS assessment as well as individualized approaches to the care plans.

During this interview, E1 also stated that E6, Charge Nurse, was present in the facility that day for her first day of training as Director of Nursing. According to E1, the Administrator was making personnel changes with the Director of Nursing to become Administrator, Charge Nurse to become Director of Nursing, and Social Service Director to become Assistant Administrator. E1 related that she was to be training the new Director of Nursing in addition to her other duties as well as studying to become an Administrator and take the test. When asked why the changes were being made, E1 indicated that the Administrator wanted to have to be in the building less.

Review of personnel file for E3, Care Plan Coordinator, included a report from outside consulting firm noting that as of 6-2-04 "MDS's (Minimum Data Set) and care plans are behind--end of April due dates on some". This report also included the comment that "