STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145680	A. BUILDING _____ B. WING _____	C 8/24/04

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF MOLINE	**7300 34TH AVENUE MOLINE, IL 61265**

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F9999	FINAL OBSERVATIONS Surveyor: 02571 STATE LICENSURE FINDINGS: 300.690a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 300.1210 b)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	F9999		

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

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F9999	Continued From page 1 device for part-time use. If there is constant 24-hour a day supervision of the door, a signal is not required. These REGULATIONS are not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that all exit doors were set in the alarmed mode to prevent one of two residents (R1) who have exit seeking behaviors from leaving the facility unattended. R1 left the facility without staff knowledge, fell into a ravine with water present, and was out of the facility overnight. R1 was admitted to the local hospital with diagnoses of hypothermia and dehydration. The facility failed to provide the Department with enough information on the incident report to ensure that appropriate action had been taken. Findings include: The incident report faxed to the regional Public Health office at 0115 on 08/17/04 states R1 "was not in her room at 2115 and could not be found after a full building check. The police were notified and were onsite". The incident report does not state the cognitive status of the resident or whether or not the resident had left the building unattended prior to this date. No age, sex, or medical condition of the resident was given. No information was provided as to what type of "investigation underway." A follow-up call to the facility at 0915 on 08/17/04 to E9 added only the information that R1 had been found in the early AM of 08/17/04 and was currently in the emergency room. R1's	F9999		

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F9999	Continued From page 2 location was noted to be "across the street". No mention was made of being found in a ravine with water present. Facility incident report dated 08/16/04 at 2100-2115 states "CNA (Certified Nurse Aide) notified this nurse that guest was missing at this time Code Brown called." Incident Investigation started by E1 (Administrator) states R1 was last seen sitting on her bed at 2100 by E2 (CNA). E2 then went on her break. When E2 returned to R1's room at 2115, E2 discovered R1 missing. Investigation report states R1 was not located until 08/17/04 at 0700-0730. R1, according to the report, was "in a ditch approx. 1/2 block from facility down a private drive." This time frame indicates that R1 was missing for over ten hours. Telephone call made on 08/19/04 to Z1 (regional weather service staff) indicated that the low temperature on 08/16/04 was 55 degrees Farenheit, and it had rained 0.12 inches during the hours of 1500-2000. It then rained again after 0730 on 08/17/04. A police report completed by the local police officer who responded to the facility's call on 08/16/04 states the local police responded to the call of a missing adult at the facility on 08/16/04 at 2147. The police report states that E1 told the police that R1 had walked out of the facility. According to the report, E1 told the police that R1 had attempted to go out the west door once and the front door several times. E1 told the officer she was not sure which door R1 may have exited. The police did a room to room search of the facility and were unable to locate R1. Local hospitals, cab companies, and nearby long term care facilities	F9999		

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were called to inquire about R1. The local canine unit was called in to search the surrounding wooded area. A helicopter, thermo-imager, and heat sensitive equipment as well as other local agencies were also utilized in the search. The police report states R1 was found at 0721 on 08/17/04 "about twelve feet down the ravine."

Hospital record reviewed contained the report from the emergency transport agency. It stated R1 arrived at the local hospital at 0739. It also states when they arrived to transport R1, the chief complaint was "possible hypothermia/possible fall. Patient missing from (facility) since 2100 found in shallow creek ravine." Review of hospital record states R1 was admitted there on 08/17/04 after having received treatment in the Emergency Room. A report written by the emergency room physician states "observed missing at 2115, found in the bottom of a ditch in two inches of rain water from yesterday." The report states the resident was awake and cold with contusions and bruising to the skin. The report also states the resident was "cold to touch initially" and had on "soaked garments." The Emergency Triage Admission form states "minor abrasions to legs; extremely cold, wet. Temperature 92.1 degrees Farenheit. Emergency Room reports also state R1 was given warmed fluids intravenously upon arrival and multiple warm blankets were applied with a body warmer unit. R1's legs were drawn up and R1 repeatedly states cold. Minor scratches were noted to both lower legs and complaints of abdominal pain when it is palpated. A progress note by Z3 (physician) written in the hospital record states R1 "was admitted to the hospital because of dehydration and hypothermia." This physician also lists as part of diagnoses-Dementia.

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F9999	Continued From page 4 R1 was observed in a hospital bed on 08/18/04 at 1:05 PM with Z2 (registered nurse) present. R1 was lying on her left side with the head of the bed elevated. R1 was slow to respond but did react to touch. R1 gave no verbal response to any questions asked but would shake her head to indicate yes or no. R1 shook her head to indicate that she was cold, worn out, felt bad, and just wanted to sleep. R1 was receiving oxygen via nasal cannula and intravenous fluids. Z2 stated that R1 spoke very little only to say cold, yes, or no. A total body examination was done and several small scratches were seen on the front of R1's right leg above the ankle and two on the backside of the right leg above the ankle. R1's left leg above the ankle had two visible scratches on the front of the ankle. R1's right hand had several small scratches on the top of her fingers near the forehand. Facility resident record of R1 was reviewed. R1 is a 95 year old who has been at the facility since 04/01/03. Diagnoses on the physicians order sheet for August of 2004 are congestive heart failure, coronary artery disease, and osteoporosis. Also on this order sheet is an order for Nitroquick 0.4 milligrams to be placed under the tongue every five minutes as needed for chest pain. Fall Risk Assessment dated 07/06/04 and current Interdisciplinary Plan Of Care in R1's record states "poor safety awareness." The Monthly Summary completed on 06/04/04 states R1 "wanders, requires use of elopement protocols, requires frequent supervision due to behavior." Social Services Progress Notes were reviewed from 04/1/03 through 07/15/04. Notes indicate that	F9999		

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R1 is confused. Entry made on 04/02/03 states "Guest tried to get out front doors. Guest is confused to where she is and why she is here." 07/07/04 entry states "Guest is a wander risk, has attempted elopement many times."

Nurses Notes were reviewed from 04/10/04 through 08/16/04. Numerous entries by staff indicate that R1 was confused and needed orientation. The notes indicate that R1 was up and about the facility independently either by walking behind her wheelchair or by propelling herself in her wheelchair. Entries also stated that R1 had made several attempts to exit the building. On 05/30/04 an entry states "1600-2000 Guest very upset and confused this shift. Ten different attempts made to exit alarmed doors." Entry of 06/11/04 states "1700 Guest was found going out back door of facility." On 08/06/04 there is a note written "2025 Guest went out front door, alarm sounded." On 08/13/04, "Guest went out door #3." On 08/16/04, "1545 pacing around facility. Attempting to exit front door....1930 Guest made several attempts to leave facility.....2015 Guest con't (continued) to attempt to leave facility....2100 CNA notified this nurse of guest missing." All of the entries on these dates were made on the evening shift.

The facility has twelve doors, numbered one through twelve, that open to the outside. Two nursing stations are in the facility, one on each side of the building. The twelve doors are divided between the two nursing stations. The alarm system has a panel of small lights located at each station with the door numbers present for the doors assigned to that nursing station. The door numbers have a light below them that is lit at all times. It stays either red (door is alarmed) or green (door is

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not alarmed). When a door is on alarm and someone opens it, the alarm will sound and the light will go green. The alarm will continue to sound until someone physically pushes the button at the nursing station to silence it; thus, re-alarming the door and turning the light back to red. Doors one through eleven are on the alarm system at all times. Door twelve is the front door of the facility. This door is directly in view of the receptionist's desk. When the receptionist is on duty and the door is in visual control, the alarm for this door is shut off. At 2000 when the receptionist goes off duty, the door is placed on the alarm system. On the day of the survey, all door alarms were tested with E1 at approximately 1745. All were found to be in working order.

Interviews were done with E1, 2, 3, 4, 6, 7, and 8. E1 (Administrator) stated on 08/18/04 that staff were monitoring R1 every fifteen minutes because she wanders and attempts to get out of the building. E1 stated that R1 was "obsessed" on 08/16/04 with going to see her daughter. E1 stated R1 has dementia and thinks she needs to care for her daughter.

E3 (CNA) stated during an interview on 08/18/04 that he saw R1 at 1255 ambulating behind her wheelchair. E3 stated that she could push the chair and walk very well. E3 stated he recalled that R1 had tried to get out the exit doors throughout the night. E3 stated this is not unusual behavior for R1. He remembers telling her on this night she could not go out because it was raining. E3 stated right before E2 notified him that R1 was missing on the evening of 08/16/04 he had noticed that the front door of the facility was not alarmed. The light on the panel was green indicating no alarm. E3

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went to the panel and alarmed the door. E3 stated the front door is placed on the alarm system after the receptionist leaves at 2000. E3 stated someone would have had to have silenced the alarm during the evening and not reset the door alarm.

E4 (LPN, Licensed Practical Nurse) was interviewed on 08/18/04. E4 stated that she saw other facility staff repeatedly take R1 away from the exit doors during the evening of 08/16/04. E4 stated she herself re-directed R1 away from the 400 exit door around 1500. E4 told R1 it was raining. E4 stated it had rained hard earlier in the day but was just "dribbling then." E4 stated that exit seeking behavior was not new for R1. E4 recalled another time when R1 got out the front door. E4 was shown the Monitoring Of Wandering Residents forms completed for R1 on 08/16/04. E4 stated the sheets indicated that R1 was being monitored every thirty minutes from 1430 until missing at 2100. E4 stated that she went out to look for R1 after she was determined to be missing. E4 stated it was "pitch black outside" and that she could see nothing.

E6 (CNA) was interviewed on 08/18/04. E6 stated that she took R1 to her room on the evening of 08/16/04 because R1 was tired. E6 stated that R1 was wearing jeans, a top, a sweater, shoes, and socks. E6 stated that R1 usually put herself to bed and refused to wear nightwear preferring to sleep in her clothes. E6 stated that she and E2 were assigned to R1's wing on 08/16/04. Two CNAs is the usual number of direct care staff assigned to that hall.

E2 (CNA) was assigned to care for R1 on

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F9999	Continued From page 8 08/16/04. E2 was interviewed on 08/18/04 and stated she last saw R1 at 2100. E2 then went on her break for ten to fifteen minutes. When E2 returned and went to R1's room, R1 was not there and could not be found. E2 was shown the Monitoring Of Wandering Residents form. E2 verified initials on the form as hers and stated that the form indicates that she was to monitor R1 every thirty minutes for her whereabouts. E7 (CNA) was interviewed on 08/19/04 and stated she was on duty the evening of 08/16/04. E7 stated that R1 had been going to different doors all evening on 08/16/04 and trying to get out. E7 stated she last saw R1 in front of the main dining room. R1 was wearing jeans, a top, sweater, and tennis shoes. E7 stated that she had been told by E3 that the front door had not been alarmed between 2100 and 2130. E8 (LPN) was interviewed on 08/19/04. E8 stated that she saw R1 around the nursing station at 1500, and that R1 was talking about leaving the facility. E8 stated R1 has tried to get out of the facility many times before this evening and tried to get out many times throughout the evening of 08/16/04.	F9999		