STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E262	A. BUILDING _____ B. WING _____	8/23/04

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENA NURSING HOME	**1010 SOUTH LOGAN P.O. BOX 427 LENA, IL 61048**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F9999	FINAL OBSERVATIONS Surveyor: 02412 Annual & IRI of 8/01/04 Licensure Violations: 300.1210a)	F9999		

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F9999	Continued From page 21 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 parttime use. If there is constant 24-hour-a-day supervision of the door, a signal is not required. [1] Based on observations, record reviews and interviews, the facility failed to have a consistently functional electronic monitoring system. The facility failed to monitor 1 of 9 residents at risk for elopement. R14 left the facility unattended and without staff knowledge. Findings include: R14 is a 76 year old resident who was admitted on 7/28/04. Among her diagnoses on the physicians order sheet (POS) dated 7/30/04 are Alzheimers	F9999		

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F9999	Continued From page 22 Disease, Dementia and Anxiety. The facility completed two pre-screenings. The Prospective Resident Information & Evaluation was done on 5/14/04 which reads, "Must be watched constantly. "The other screening done two days before admission on 7/26/04 reads, "Needs watched, Wanders." According to the "Interdisciplinary Notes", R14 was admitted on 7/28/04 and a electronic monitoring device was applied to her left ankle. On 7/29/04 R14 made four unsuccessful attempts to leave the facility unsupervised. On 7/31/04 R14 again attempted to leave the facility unsupervised, but was "brought back in the facility with much encouragement." Facility's FHN Falls Occurrence Form dated 8/01/04 reads, "0900 Resident outside of facility without assistance. Returned to facility by nurse no injuries noted. Resident dressed per weather conditions. Electronic Monitoring Device on left ankle. Alarm system did not sound. Unsure where resident exited. E7, (Licensed Practical Nurse) was interviewed on 8/17/04 at 8:45 A.M. E7 provided the following information: R14 was last seen leaving the dining room 8:45 A.M. on 8/01/04. E8, (Registered Nurse) was interviewed on 8/17/04 at 8:30 A.M. per telephone. E8 provided the following information: At approximately 9:00 A.M. on 8/01/04, E8 was driving home when she noticed R14 walking in the local bank parking lot, which was a half mile from the facility and on the opposite side of the street. E8 was able to	F9999		

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F9999	Continued From page 23	F9999		

convince R14 to get into her car so she could return R14 to the facility.

Z1, R14's husband was interviewed at 7:40 A.M. on 8/17/04 per telephone. Z1 provided the following information: R14 was admitted to the facility because R14 was wandering and trying to leave the house unsupervised. R14 even tried to leave in the middle of the night. Z1 stated, "She was not safe to be outside by herself." R14 also had a history of falls at home. On 8/09/04, R14 was discharged to a facility out of state.

E1, (Administrator) was interviewed on 8/16/04 at 12:02 P.M. in E1's office. E1 provided the following information: There are three exit doors that are alarmed with the wrist/ankle electronic monitoring device. These doors are the north and south main entrance doors and the staff door. The rest of the exit doors alarm automatically when opened and lead to fenced in areas. Through E1's investigation, the alarms did not sound the morning of 8/01/04, when R14 left the facility unsupervised. The alarms need to be reset with a touch key pad at the door in order to silence them. According to E1, the wrist/ankle electronic monitoring device was checked when R14 was returned and at that time the system was functioning properly. Environmental services is in charge of checking the system daily and the nurses are in charge of checking the actual bracelets daily.

E12, (Environmental Services Supervisor) was interviewed on 8/17/04 at 9:30 A.M. E12 provided the following information: The electronic monitoring system is checked by looking at the system's boxes on the doors for a green light. If the green light is on it's working. The nurses check the actua

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F9999	Continued From page 24 bracelet by holding it under a device that notes it has power. At no time does staff put a bracelet on or hold a bracelet and attempt to exit the doors to see if the system actually functions the way it is suppose to. On 8/16/04 at 1:48 P.M. observations were made with electronic monitoring device on left ankle. The alarm failed to sound 4 of 14 times when tested by walking through the North front door. The South front door and the staff door both failed 2 out of 4 times. E9, (Corporate Maintenance) was present during testing. E9 was interviewed on 8/17/04 at 8:00 A.M. E9 provided the following information: E9 found out that the sensitivity was set incorrectly and needed to be adjusted in order to consistently detect the electronic device on the ankles of residents.	F9999		