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	145371	A. BUILDING _____ B. WING _____	C 09/01/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF BLOOMINGTN	**1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701**

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F 324	Continued From page 12 Instructions were posted for how to reset the alarm panel. On 8-30-05 at 5PM the motion detector was deactivated, at which time a staff person was placed at the nurses station to visually watch all doors, specifically residents who entered and exited the two 200-wing doors (smoking area and patio area). The staff monitors will be in place 24 hours a day until a camera to monitor the 200-wing smoking areas could be adjusted to monitor all smokers on the 200-wing smoking area and the general door alarm system can be inspected by an electrician and alarm system company to assure proper function. The third shift nursing staff was inserviced on 8-30-05 by the DON that two hour checks are done on all residents. Additional inservices were held on 8-31-05 and 9-1-05 for completing two hour rounds for all residents, awareness of whereabouts of smokers and Certified Nurse Aides to perform walking rounds at the beginning and end of shift. On 8-31-05 the camera monitoring system was adjusted to view all residents for the 200-wing smoking area. An electrician and alarm system expert will analyze the general alarm system for proper function and correct any problems on 9-02-05 at 7:00 am.	F 324		
F9999	FINAL OBSERVATIONS STATE VIOLATIONS ASSOCIATED WITH THIS SURVEY:	F9999		

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F9999	Continued From page 13 300.1210 a) 300.1210 b) 6) 300.3100d) 2) 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. Personal Care, as defined in section 300.330, is assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual (Section 1-120 of the Act) 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. All exterior doors shall be equipped with a signal that will alert that 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 signal is	F9999		

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not required.

These regulations are not met as evidenced by:

Based on observation, interview and record review the facility failed to consistently implement their system of supervision for residents. Staff failed to have proper functioning general alarm devices on 2 of 9 exterior doors accessible to residents, to alert staff when a resident exits the building. Staff also failed to ensure proper function of one of nine electronic door monitoring alarms. R1, one of the 16 cognitively impaired residents with known exit seeking behaviors, and R19, one of eight residents who smoke independently outdoors, left the facility without staff knowledge or supervision.

Findings include:

1. R1's Admission and Discharge Summary Sheet dated 8-15-2005 documents R1 was admitted with diagnoses that include Alzheimer ' s disease, Dementia and Cerebral Vascular Accident; R1 is aphasic. R1's most recent Minimum Data Set (MDS) dated 5-30-05 documents R1 is moderately cognitively impaired, ambulates independently, has behaviors of wandering daily, with no rational purpose, and is "seemingly oblivious to needs or safety."

R1's care plan, dated 6-7-05, identifies R1 as having wandering behaviors with a goal of "to not wander out of the facility." Approaches include: a wandering assessment is to be done quarterly; a safety alarm device on her wrist which is to be checked daily; staff to re-direct when going near

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F9999	Continued From page 15 exits; and half-hour checks on R1's whereabouts. The facility's Elopement Risk Assessment Tool, dated 3-4-05, identifies R1 as at risk for elopement (leaving the facility without staff knowledge or supervision). This assessment includes a notation of 5-30-05 that R1 remains at risk. Nurses ' notes dated 8-5-05 at 4:30PM document that R1 attempted to go out the 200-hall patio door two times and became combative when returned to the building. At 5:00PM, according to nurse's notes on the same day, E3 Licensed Practical Nurse (LPN) was in the dining room passing medications when dietary employee (E4) noticed R1 out by the stop sign at the intersection of the street which passes the front of the facility and a second busy street. E3 and E4 ran out to the corner and brought R1 back with some resistance. Observation of the area where R1 was found was done on 8-22-05 at 10:15AM. To reach the location from all facility exits, one would cross a parking lot of approximately 200 feet to the sidewalk that runs along the street. This street is known to be, and was observed to be, busy with automobile traffic. The facility's Incident Report dated 8-5-05 and signed by E1 Administrator states R1 left the facility after 4:30PM check, and R1 was on half-hour checks. Staff returned R1 to the facility. R1 was approximately 200 feet from the front entrance. E3, LPN, on 8-22-05 at 2:20PM provided the	F9999		

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following information regarding the incident with R1 on 8-5-05. On 8-5-05 between 4:00PM and 4:30PM R1 went out the patio door on 200 hall and E3 brought R1 back. At around 5:00PM E3 went to the dining room to pass medications. E4 saw R1 out the window and E8 Certified Nurse Aide, and E3 went out and got R1 just beyond the parking lot. By the time E3 and E8 got to R1 she was at the stop sign at the intersection of the street which passes the front of the facility and a second busy street. No one heard R1's alarm go off, but when R1 came back in through the front door the alarm sounded. All staff was in the dining room for the evening meal at the time R1 was observed outside. No staff remained at the nurse's station or on the hall during this time.

The facility's system of supervision includes the use of two exterior alarm systems. Each exterior door with the exception of the two 200-wing exterior doors is equipped with a general audible alarm. On the 200-hall, one door exits to the patio and the other one to the outside smoking area at the end of the hall. These two doors only have the alarm which works in concert with residents wearing an electronic monitoring device. All exterior doorways are equipped with a second alarm system that works with electronic monitoring devices on those residents identified at risk for elopement.

E5, Assistant Supervisor of Maintenance, provided the following description of the facility's system of resident supervision on 8-25-05 at 1:45PM. The facility utilizes two audible alarm systems to help supervise residents. The general audible alarm and the electronic monitoring device safety alarm. The general

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F9999	Continued From page 17 audible alarm is on seven of the nine doors that are accessible to residents. The two doors on the 200-wing are equipped only with the electronic monitoring device alarm. The exterior door at the end of the 200-hall where residents smoke is equipped with hardware for the general alarm, but staff have disarmed the alarm. The end of the 200-wing has an enclosed area with a latched gate. This gate is not alarmed. The electronic monitoring safety alarm is on all nine exterior doors accessible to residents. This audible alarm sounds only when a resident wearing an electronic monitoring bracelet opens the door. This alarm also registers on a panel at the nurse's station and must be manually reset at this panel and the door. E5 continued to provide the following information on 8-25-05 at 1:45PM. E5 stated that he was not notified of the elopement of 8-5-05 until 8-8-05. The general and electronic alarm systems were not checked for proper function until 8-8-05 during E5's routine check. E5 stated he identified a problem with the electronic monitoring alarm on the exterior door at the end of the 200-wing on 8-8-05. The locking mechanism of the electronic monitoring device alarm system was broken, so it would not automatically reset and activate the alarm. E5 stated if R1 would have went through the 200-wing end door when the key was off, the alarm would not have sounded. E5 stated he informed the Administrator and nursing of the non-functioning door alarm on 8-8-05. The general alarm for the 200-wing end door was not put back into use at this time nor were any other supervision interventions or alternate alarm systems implemented until the door alarm was	F9999		

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repaired. E5 clarified that the door alarm was not repaired until 8-12-05. At the time of the incident and continuing through interview of 8-25-05, the facility did not have a general alarm signal functioning on either of the two exterior doors on the 200-wing. E5 stated that he suspected that R 1 went out the door at the end of the 200-wing with no general alarm on
Monday, 8-8-05.

On 9-1-05 at 2:00PM E5 stated he had provided incorrect information regarding the available general alarm hardware for the 200-wing patio door during the interview of 8-25-05. E5 stated both the 200-wing end door and the patio door were equipped with general audible alarm hardware at the time of the incident of 8-5-05, but both these alarms had been disarmed by staff prior to 8-5-05.

Interview with E5 on 8-22-05 at 1:45PM related that he checks door alarms every day Monday through Friday to be sure they are functional. No checks of the door alarms are conducted on the week-ends. There is no written documentation of these checks.

On 8-22-05 at 10:30AM R1 was unable to respond appropriately to questions asked and seemed confused. According to interview with E 2, Director of Nurses on 8-22-05 at 11:00AM, R1 spends most of the day walking up and down the halls. R1 was observed on
8-23-05 walking the hall most of the day. R1 was interviewed again on 8-24-05 at 10:15AM R1 did not have the ability to make appropriate responses to questions.

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F9999	Continued From page 19 Interview with E1 on 8-22-05 at 3:30PM provided information that 16 residents currently in the facility are considered at risk for wandering and have electronic monitoring devices to assist staff in supervising and detecting their departure from the building. 2. On 8-29-05 at 11:10AM, Administrator E1 was called; during this conversation E1, informed IDPH that a second resident had left the building without staff's knowledge. R19, a 48-year old resident, was discovered missing on 8-29-05 on the 4:00AM rounds. E1 stated that R19 had received his medications at 8:00PM on 8-28-05 and went to the smoking area after that; R19 did not sign out. E1 stated that the police had been called, family notified and R19 had still not been located at that time. On 8-30-05 at 9:00AM E1 stated that R19 walked back in the facility earlier the morning of 8-30-05. E1 stated that R19 was alert and oriented and stated that he said he had been staying with, "a friend". Director of Nurses (DON) E2 stated on 8-30-05 at 9:00AM that Z2 had called the facility on 8-29-05 stating that R19 had called her to let her know that he was okay, and that he would be returning that day. E2 stated R19 did not return until 8-30-05. R19's August Physicians Order sheet list diagnoses which include Seizure Activity and Alcohol Abuse; R19's initial MDS dated 7-15-05 shows no memory problems and difficulty with decision making with new situations only. The MDS documented R19 was receiving Occupational Therapy and Physical Therapy.	F9999		

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F9999	Continued From page 20 Physician's notes dated 8-17-05 document that R19 had sustained an intercerebral hemorrhage and seizure in June of 2005 that has little residual deficit. Per interview with Social Service Director, E7 on 8-30-05 at 10:20AM and review of social service notes, R19 was admitted to the facility from the hospital after having a seizure at work, falling from a ladder and hitting his head. R19 had generalized weakness and was admitted for therapy. A social service note of 8-26-05 documents R19 was to complete his therapy within the week and is awaiting discharge placement. R19 was interviewed on 8-30-05 at 9:20AM R19 stated that the night before last, he decided he wanted to get away for a while, so around 8:00 PM he went out the smoking gate and walked to a friend's place. R19 stated he did not tell the staff he was leaving and did not sign out, because he didn't know he had to. R19 stated his friend dropped him off at the facility this morning. R19 displayed good recall and understanding of his actions and had safety awareness. Direct care staff who were working R19's wing on the evening and night shifts on 8-28 and 8-29-05 were interviewed per telephone on 8-30-05 including LPN E17, CNA E16, CNA E18, and CNA E19. The last person who saw R19 was LPN E17. Based on interviews, R19 was absent approximately 8 hours before staff became aware. LPN E17 stated, during interview on 8-30-05 at 2:30PM, that she had given R19 his medications on 8-28-05 around 8:15PM; E17 stated R19 then	F9999		

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walked toward the Nurse's station. E17 stated that she did observe that R19 was not in his room at midnight on 8-28-05 but she did not think it was unusual because it was R19's routine to go frequently outside to smoke. E17 stated the alarms were armed and she did not recall hearing any alarms. E17 went off shift at 1:00AM on 8-29-05 without verifying R19's whereabouts.

CNA E16 confirmed during interview on 8-30-05 at 4:30PM that she had worked the 200-wing and 400-wing on the evening shift on 8-28-05, and had worked the night shift on the 100-wing and 300-wing. E16 stated that she had come on shift at 8:00PM and left at 5:45AM on 8-29-05. E16 stated that she never saw R19 at all. E16 stated that she had not gotten a chance to do the 10PM bed check on R19's hall before she switched wings. E16 said she did tell the next shift that she hadn't done bed checks. E16 stated "We don't keep tabs or regular checks on residents who go out independently to smoke."

CNA E19 confirmed during interview on 8-30-05 at 1:40PM that she had worked nights on R19's wing on 8-27-05. E19 stated she did not see R19 and that she had not done bed checks for R19 or roommate R20 as they are independent with Activities of Daily Living and can use the call light . E19 didn't realize R19 was missing until 4AM.

RN E20 documented on 8-29-05 4:10AM in R19 's nurse's notes that she became aware that R19 was not in the building when roommate (R20) informed her that R19 was not in his bed and that he was worried about him because he was upset earlier.

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R20 was interviewed on 8-30-05 at 9:35AM; R20 stated that he woke up at midnight and saw R19 was gone but thought he was out smoking. R20 confirmed when he woke up around 3:30AM, and saw R19 was still gone, he told the nurse E20.

On 8-30-05, at approximately 12:05PM R19 was observed sitting outside in the side patio of 200-wing. R19 confirmed that he had come out of the facility via the side patio door on Sunday night (8-28-05). R19 stated he was out in the courtyard for about 5 minutes and then and went right out the gate. R19 stated that no one was on the patio at the time. R19 stated that staff might have seen him go out and thought he was going to smoke and that was it.

Per interview with E1 and E2 on 8-30-05 at 4:30 PM the facility has no system in place for monitoring the residents who go outside independently to smoke other than noting who is exiting the building when the alarm sounds. The independent smokers have no restrictions for when or how long they are outside smoking. Residents who want to leave the grounds are to inform a staff and sign out. Per review of the resident smoker list there are eight residents who are independent smokers.

3. On 8-30-05 at 12 Noon, Office staff E11 went out the 200-wing side patio exit. No alarm sounded at the nurse's station. The surveyor then went out the same door and came back in with E11, and R20 went out within a minute after that and no alarm sounded at the nurse's station. DON E2, and RN E12, confirmed that the light on the alarm panel was red which indicated that the alarm was armed. R19 went out the side patio

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door at approximately 12:04PM and no alarm activated. E2 began pushing the reset button for the 200-patio and the alarm began to function.

Maintenance Assistant, E5 stated on 8-30-05 at 12:30PM, that all door alarms had been checked each morning including the side door and they had been functioning. E5 stated that he just looked at the 200-wing patio door after it was noted that the alarm did not sound. E5 stated that he lubricated the ball switch on the door frame to make sure it wasn't sticking. At 4:30PM E5 stated that there was no preventative maintenance program to lubricate the ball switches for the general door alarms that he was aware of.

On 8-30-05 approximately 4:20PM LPN, E15 was observed repeatedly hitting the 200-patio reset button to reset the door after residents had gone out to the patio. She stated that it wouldn't reset with the door open.

On 8-30-05 at 4:45PM E1 and E14 were questioned about the alarm panel reset. E1 and E14 stated that when the alarm sounds the red light flashes, if you just hit the button quickly and don't get a green light, then the red light will stay on, but the system will not reset. The light will stay red and it will look like it is engaged but it is not. You have to push the reset button fully, get a green light, then push the button again for a red light to ensure the system is activated. E1 stated that the staff had been recently in-serviced on this system.