STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145716	A. BUILDING ______ B. WING ______	C 08/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANGAMON CARE CENTER	2800 WEST LAWRENCE SPRINGFIELD, IL 62704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 324	Continued From page 3	F 324		

off on both sides of the five foot wide sidewalk about 40 feet from the exit door. This drop off continues over a metal drainage pipe and on to the blacktop parking lot in the front of the facility about 80 feet from the exit door.

On 08/22/06, at 1:30 pm, E1 (Administrator) and E2 (DON) were notified of the Immediate Jeopardy. The facility had taken the following actions to remove the immediacy:

On 08/10/06:
6:00 pm: A complete door alarm check was done by nursing staff. Resident was put on 15 minute checks for 72 hours.
6:30 pm: Resident was examined and vitals completed with no injuries noted. Physician and family notified.
6:30 - 7:30 pm: Interviews of staff on duty completed with reenactment of events to try to determine how resident exited. Z1 interviewed at 7:35 pm.
6:30 - 9:30 pm: Inservice and education completed with staff on duty.
8:30 pm: Maintenance staff did an additional check of door alarms. Walk of building and perimeters by maintenance and Director of nursing done to attempt to find out how resident got out. No exit method determined.
On 08/11/06:
R1's care plan reviewed and updated. Daily door alarm checks initiated by maintenance.
On 08/11/06 through to the present:
Focused rounds conducted by facility supervisory staff involving asking staff questions related to elopement policies and procedures to ensure staff education is appropriate.

F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 4 Licensure Violations 300.1210a) 300.1210b)6) 300.3100d)2) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 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. b) 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 300.3100 General Building Requirements d)2)All exterior doors shall be equipped with a signal that will alert staff if a resident leaves the building. These requirements are not met as evidenced by : Based on observation, interview and record review the facility failed to provide adequate supervision to prevent the elopement of one	F9999		

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F9999	Continued From page 5	F9999		

resident (R1) of 17 residents assessed by the facility to be elopement risks at the time of the incident. This failure resulted in R1 eloping from the facility without staff knowledge on 08/10/06. R1 was found outside the East exit door with a passerby who was knocking on the door attempting to help R1 get back in the facility. No staff on duty at the facility heard a door alarm or knew that R1 eloped.

Findings include:

The facility's incident investigation of 08/10/06 indicates that R1 was found by Z1 (visitor) and E 9 (Certified Nurses Aide - CNA) just outside the East exit door on the cement area, at 5:45 pm.

On 08/22/06, at 10:45 am, Z1 indicated that she went to visit with R1 on the evening of 08/10/06 as she does quite often. Z1 indicated she first put R1's laundry in R1's room. Then she walked down to the dining room to look for R1. She asked the available CNA's if they knew where R1 was and they said, "no." E8 (CNA), E9 (CNA) and Z1 went to look for R1. Z1 indicated as she went down the East wing she heard someone knocking on the exit door, from the outside, at the end of the hall. She could see through the window it was Z3 (passerby) who was knocking and R1 was out there with her. R1 was brought back in through the front entrance by E8 and Z1.

Incident investigation report of 08/11/08 states " Immediate assessment of R1 found no injuries." This report also indicates that all door alarms were found to be working properly including R1's personal bracelet alarm.

On 08/22/06 at 2:30 pm, E9 indicated that she

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F9999	Continued From page 6	F9999		

got R1 up at 5:00 pm and took her to the dining room. E9 said she then went back to get the rest of her assigned residents on the West hall. E9 indicated Z1 came about 5:30 pm.

On 08/18/06 at 2:30 pm, E8 indicated it was about 5:35 pm when Z1 came to her asking where R1 was located. E8 indicated she told Z1 that she had just seen E9 push R1 in her wheelchair into the dining room five minutes ago.

Interview with E2 (Director of Nurses) on 08/18/06 verified the above indicated events of the incident.

The outdoor temperature was 82 degrees at 5:00 pm according to National Weather Service records.

R1's Physician's Orders sheet dated 08/01/06 indicates she has diagnoses which include: Alzheimer, Dementia with psychotic features and anxiety.

R1's resident full assessment form dated 06/06/06 indicates R1's Cognitive Skills for Daily Decision-making is at the Moderately Impaired level. This MDS also indicates R1 has short-term and long-term memory problems.

R1's assessment dated 06/05/06 states, "Resident has difficulty with decision making... Resident responds to yes/no questions at times but usually does not respond appropriately to questions. Residents speech is disorganized and out of context."

R1 was interviewed on 08/18/06. As the above assessment indicates, R1 did not respond

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F9999	Continued From page 7 appropriately to questions and her speech was disorganized and out of context. On 08/22/06 at 12:15 pm, Z2 (R1's Physician) indicated that R1's cognition is "pretty poor...she has no idea where she is." Z2 indicated R1 can be feisty, "needs lots of supervision," is not aware of safety concerns "at all," nor would she be able to avoid hazards in her environment. The nursing home is located in a residential neighborhood with a heavily-used fitness center across the street and a four lane highway (speed limit 55 miles per hour) one block away. The spot where R1 was found is the cement landing just outside the East exit door. This landing is where a cement sidewalk begins with a 90 degree turn north. This sidewalk runs along a grassy area and starts with a small drop of 2 inches. The drop off gradually gets bigger until it is a 10 inch drop off on both sides of the five foot wide sidewalk about 40 feet from the exit door. This drop off continues over a metal drainage pipe and on to the blacktop parking lot in the front of the facility about 80 feet from the exit door. (A)	F9999		