PRINTED: 02/27/2008 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146045	B. WIN				C <b>1/2007</b>
	ROVIDER OR SUPPLIER	RGY	· ·	2	REET ADDRESS, CITY, STATE, ZIP CODE 210 EAST COLLEGE ENERGY, IL 62933	,	.,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	τS	F	000			
	Complaint Investiga 0752512 / IL29 0752582 / IL29	242 ==> F324					
F 324 SS=J			F	324			7/19/07
33-3		nsure that each resident supervision and assistance accidents.					
	by: Based on observat interviews, the facil supervision for 1 of as a wander-risk fo	NT is not met as evidenced ion, record review, and ity failed to provide adequate 2 sampled residents identified r elopement and with previous rom the facility (R1).					
	for elopement that device. R1, who is decision making, a requires staff assis an unsteady gait, le without staff's know	ed 18 current residents at risk wear an electronic monitoring cognitively impaired for trisk for elopement, and who tance with ambulation due to eft the facility on 06-05-07 pledge. R1 was found lying in lential area. R1 sustained these from a fall.					
ABORATOR	Jeopardy. While the removed on 06-05- returned to the faci remains out of com actual harm with the minimal harm for face	ulted in an Immediate e Immediate Jeopardy was 07 when the resident was lity by the police, the facility pliance at a level that is not e potential for more than illing to implement a system	NATI IDE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION  IG	(X3) DATE SU COMPLE	TED
		146045	B. WII	NG _			C 1 <b>/2007</b>
	ROVIDER OR SUPPLIER	RGY		2	REET ADDRESS, CITY, STATE, ZIP CODE 210 EAST COLLEGE ENERGY, IL 62933	00/2	172007
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 324	that assures supervithe door alarm soul alarms are operation	vision of the exit doors when nds and assuring all door onal. The front door alarm on C ional when checked on	F	324			
	The findings include	e:					
	facility on 03-16-07 Lung Mass, Weight Disease, and Alcoh Nursing Admission 03-29-07. A psychio 06-10-07 states R1	resident admitted to the with diagnoses that include: Loss, Dementia, Depressive of Abuse according to the History and Physical dated atric assessment dated has Severe Dementia with ory, judgement, executive ion.					
	states R1 is moderadecision making (derequired). R1 was a limited assistance of assistance for transwith one person as off the unit. The ME	a Set (MDS) dated 03-30-07 ately impaired for daily ecision poor cues/supervision also assessed to require of 2 plus person physical sfers and total dependence sistance for locomotion on and DS and facility's initial ment dated 03-16-07 did not opement risk.					
	propelling himself in On 06-12-07 at 3:1 a walker with assist unsteady. R1 was a monitoring device on his wheelchair.	on 06-11-07 at 11:40AM on a wheelchair with his feet. 5PM, R1 was ambulating with tance; his ambulation was observed to have an electronic on his right wrist and another An electronic monitoring of by the physician and placed					

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F 324	on R1 after an atter according to the fact 05-04-07. An elope completed on 05-04 elopement risk. R1' 05-04-07 with apprelopement.  The facility incident interviews with E7 06-13-07 at 9:16AN seen in the facility wheelchair at 1:45AN the local facility and asked if police found R1 at street. The police ropick up R1. Before located to go get R returned R1 to the According to E7's in completed when R1 noted on both of R2 electronic monitorir right wrist and sour through the front do with neurological cl. All door alarms were and R1 was placed by staff. R1's electrout of 5 times where interview with E7 of	mpted elopement on 05-04-07 cility incident report dated ment re-assessment was 4-07 identifying R1 as an s care plan was updated on oaches for R1's risk for report dated 06-05-07 and (Registered Nurse) on a confirmed that R1 was last going into his room in a a confirmed that R1 was last going into his room in a a confirmed that R1 was last going into his room in a confirmed that R1 was last going into his room in a confirmed that R1 was last going into his room in a confirmed that R1 was last going into his room in a confirmed that R1 was last going into his room in a confirmed that R1 was last going into his room in a confirmed that R1 was last going into his room in a confirmed that R1 was interviewed the same and some one to other facility staff could be confirmed. Abrasions were confirmed. Abrasions were confirmed. Abrasions were confirmed when he returned confirmed and when he returned confirmed and confirmed at the confirmed to sound 3 confirmed at the door according to confirmed at the confirmed	F	324				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (IDENTIFICATION NUMBER:  A. BUILDING			IPLE CONSTRUCTION IG	(X3) DATE SU COMPLE	JRVEY TED
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	PROVIDER OR SUPPLIER  EALTHCARE OF ENE	RGY	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 110 EAST COLLEGE ENERGY, IL 62933		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 324	According to the 06 interview with Z2 (p 2:35PM, the dispate approximately 3:16 the street at 303 Br Upon Z2's arrival at flat in the street in stresponded to Z2 the could not walk. An atold Z2 that he had Chicago to Alabam bicycle. R1 knew hi was not aware of his residence.  A search of the are approximately 100 driveway on Ford sthat R1 had crawled the grass. Z2 stated knees, and it looked knees several times appropriately dress and had an electroright wrist. Z2 had facility and ask if the facility was unaware facility at that time, per ambulance, and alarm sounded whe facility.  E7 was interviewed stated R1 was up a eloped. He talked to sick wife. This was and dressed at night	ge 3 i-05-07 police report and police officer) on 06-12-07 at cher received a phone call at AM that a man was laying in enda Lane calling for help. In elderly black man was lying some apparent distress. R1 at he had leg injuries and ambulance was requested. R1 been riding a bicycle from a and had fallen off the sname and date of birth but its location or his current a discovered a wheelchair yards away from R1 in a treet. Z2 stated it was obvious discress 2 residential lawns in direct. Z2 stated R1 was ed in pants, shirt, and shoes his monitoring device on his the police dispatcher call the ey were missing R1. The exit was missing from the R1 was returned to the facility difference the electronic monitoring en R1 was brought back in the lone of 12-07 at 9:16AM. E7 and dressed the night he of her about going to see his not unusual for R1 to be up int and to wander in the halls.	F	324			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTI LDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  EALTHCARE OF ENE	RGY		2	REET ADDRESS, CITY, STATE, ZIP CODE 10 EAST COLLEGE ENERGY, IL 62933		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 324	wanders in the halls doors frequently se interview with R1 o worked the night sh system and usually E3 (Licensed Pract Coordinator) was ir 11:40AM. The facilihistory of night shift This was not included identify times and a elopement, confirm R1's care plan date elopement and war	ical Nurse-Care Plan httriewed on 06-13-07 at tity was unaware of R1's past twork and eating patterns.	F	3324			
	elopement. The cuthe 15 minute wher monitoring device a after the 06-05-07 confirmed with E3 during the daily sta	continued to attempt arrent care plan did not identify reabouts checks and the extra applied to R1's wheelchair elopement. This was on 06-13-07 at 11:40AM tus meeting.					
	06-05-07 the weath	ner for Energy, IL ranged from es to a low of 72 degrees with					
	was oriented to per facility in Chicago, current residence. I at night recently an something to eat. R wheelchair when he grass was slippery.	d on 06-11-07 at 11:40AM, and son but thought he was in a IL. R1 did not know the date or R1 recalled leaving the facility d stated he went out to get R1 stated he fell out of the e came to a ditch. He said the He fell and crawled up the R1 stated when he fell the 2nd					

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		146045	B. WIN	G			C <b>1/2007</b>
	ROVIDER OR SUPPLIER	ERGY	,	210	ET ADDRESS, CITY, STATE, ZIP CODE DEAST COLLEGE ERGY, IL 62933	00,2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 324	time, he hurt his let stated he was "sca time". R1 was not as ditches, but stat of a car.  According to interv 9:16AM, R1 would hazards and would where he resides.  The Helia Healthca East College Stree is 1 block east of th 148 (Pershing Stree 2-lane blacktop roat traffic observed on road is narrow with side. A steep ditch the north of the fac smaller ditch is in f	it knee and shoulder. R1 red" and was "gone a long aware of safety hazards such ed he would get out of the way liew with E7 on 06-12-07 at not be aware of safety not be able to tell someone are of Energy is located at 210 t in Energy, Illinois. The facility he busy 4-lane road Route IL et). College street is a busy ad with frequent car and truck 06-11 through 06-14-07. The no shoulder present on either is located across the street to ility on College Street, and a ront of the facility. A large ed past the ditch with a parking	F3	24			
	street in a resident park. In a wheelch block east on Colle on Front Street. R on Ford Street, the street, and back we houses. R1 was fo in front of the hous Lane. Several stee bordering the Colle Z1 (physician) state 06-18-07 at 9:50AM	mile from the facility in the fal area, 1 block north of the air R1 would have traveled 1/2 toge Street, then north 4 blocks 1 then traveled west 1/2 block in 1/2 block north on Tucker est on Brenda Lane past 3 und in the middle of the street e at the address 303 Brenda p ditches were noted toge, Ford, and Taylor streets.  The deep red per phone conversation on M, that R1 has a Dementia sed, and needs to be in a					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		LE CONSTRUCTION	COMPLE	TED
		146045	B. WIN	G			C 1/2007
	PROVIDER OR SUPPLIER	ERGY		210	EET ADDRESS, CITY, STATE, ZIP CODE D EAST COLLEGE NERGY, IL 62933	03/2	172001
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 324	nursing home. Z1 safety hazards nor unsupervised.  According to a prev 05-06-07 at 11:45A facility and fell in the his head and receive the nose and foreh According to the nuexited out the west sounding. R1 was dining room. The fallocation checks on his electronic moniaccording to intervi 11:40AM.  R1 also left the fact 05-26-07 at 2:30PN incident report and running through the apparent injuries (relectronic monitoric door did not sound when opened. According to interviate the sound when opened. According to interviate the sound when opened. According to interviate the sound when opened. According the initial to with E3, the door be door did not sound when opened. According to interviate the sound when opened and the sound when opened and the sound when opened and the electronic monitoric coded off at the doceases to sound for electronic monitoric monito	stated R1 would not know be safe out of the facility vious incident report on AM, R1 walked outside the legrass on his knees. R1 hit wed several small abrasions to lead as well as a busted lip. Lurses notes on this date, R1 of door without the alarm seen 10 minutes before in the facility performed 15 minute R1 for 24 hours and changed toring bracelet on 05-07-07, iew with E1 on 06-13-07 at illity by the front door on M according to the facility nurse's notes. R1 was seen to parking lot and fell with no mo mention if the door alarm or light up at the nurse station cording to interview with E5 06-11-07 at 10:55AM, the inded or lit at the nurses station or light up at the nurses station and the cording to the facility with E5 unded or lit at the nurses station or light up at the nurses station and the cording to lit at the nurses station and the cordinal cordinal to the nurses station and the cordinal cordinal to the nurses station and the cordinal cordinal cordinal to the nurses station and the cordinal cor	F3	24			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUBBLIED/CLIA

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE S COMPLI	ETED
	146045	B. WIN	G		C 2 <b>1/2007</b>
NAME OF PROVIDER OR SUPPLIER  HELIA HEALTHCARE OF ENERG	GY		STREET ADDRESS, CITY, STATE, ZIP COD 210 EAST COLLEGE ENERGY, IL 62933	•	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL INFORMATION)	ID PREFI) TAG		SHOULD BE	(X5) COMPLETION DATE
door is closed. This a to turn off the alarm.  Per interview with E7 phone, E7 stated the always heard by staff rooms as the buzz is like the call light buzz respond to the door be stated by E7.  E11 (Certified Nursing door buzzer sounds wo opened and the buzz heard when staff are the break room accor 06-13-07 at 10AM per The Immediate Jeopardy begun on 06-05-07 we without staff knowled found at 3:15AM by the facility. The Immediate Jeopardy begun on 06-05-07 we without staff knowled found at 3:15AM by the facility at approximation ambulance service as by staff and placed on electronic monitoring determined defective door buzzer alarms we determined to be in we when R1 was returned.	a opened and quits when the alarm does not require staff  on 06-12-07 at 9:16AM per open door buzzers are not f when they are in resident's a low frequency and sounds zer. Staff do not always ouzzer as it sounds often,  g Assistant) also agreed the when the exit doors are zer sounds are not always in a resident's room or in rding to interview on er phone.  ardy was presented to E1 in 12-07 at 1:00PM. The was determined to have when R1 left the facility ge after 1:45AM and was he local police 0.8 mile north amediate Jeopardy was time he was returned to mately 3:30AM by the mod police. R1 was assessed in 15 minute checks. The system was checked and and replaced. E1 stated the were checked and vorking order on 06-05-07	F3	324		

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, ID I LAIN C	O CONTROLLON	A. BUILDING					
		146045	B. WIN	IG _			C 1/2007
	ROVIDER OR SUPPLIER	RGY		2	REET ADDRESS, CITY, STATE, ZIP CODE 10 EAST COLLEGE ENERGY, IL 62933		
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F 324	knowledge on 06-0  1. On 06-05-07, the alarm systems to we electronic monitoring properly. It was det monitoring device wand was replaced.  2. On 06-05-07, Rowas assessed and initiated, and an addevice was applied.  3. On 06-14-07, Rowas approaches revised patterns, added a work chair, and 15 minute.  4. On 06-05-07 at 11:45AM, all staff work yellow to include the use of a to check all resident devices every shift on 06-14-07 of this inserviced on the dochecks for elopement just visual checks.  6. All residents that wandering risk will every 15 minutes un longer be found.  7. On 06-15-07 and.	e facility staff reviewed the erify that all door alarms and and devices were functioning ermined that R1's electronic was not functioning properly  1 was returned to the facility, 15 minute checks were ditional electronic monitoring to R1's wheelchair.  1's care plan was updated and do to include R1's past lifestyle wheelchair alarm on R1's the checks.  11:00PM and on 06-08-07 at were inserviced on "Code the monitoring of door alarms.  It is facility policy was updated to a hand held monitoring device at selectronic monitoring and staff were re-inserviced change. Staff were also occumentation of 15 minute ent risk residents instead of the monitored for location and they are re-evaluated and they are re-evaluated and	F3	324			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
			A. BUI	LDING	G		С
		146045	B. WIN	IG			1/2007
	ROVIDER OR SUPPLIER	RGY		21	EET ADDRESS, CITY, STATE, ZIP CODE 10 EAST COLLEGE NERGY, IL 62933		
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F 324 F 441 SS=E	door buzzers.  8. On 06-11-07 at alarm was repaired nurses station whe 483.65(a) INFECTI  The facility must es infection control prosafe, sanitary, and to prevent the devedisease and infection control investigates, control investigates, control the facility; decides isolation should be resident; and maint corrective actions r  This REQUIREMEI by:  Based on record reinterviews, and revifor the past six mor maintain an effectivand an accurate infithe transmission of (rashes) for R11, R sample.  Findings include:  1. Review of the inpast 6 months reverences at a large repair of the past 6 months reverences.	2PM, the C Hall front door I to sound and light at the in the door is opened. ON CONTROL  stablish and maintain an orgam designed to provide a comfortable environment and elopment and transmission of ion. The facility must establish program under which it ols, and prevents infections in what procedures, such as applied to an individual trains a record of incidents and elated to infections.  NT is not met as evidenced eviews, observations, iew of the infection control log inths, the facility failed to be infection control log to prevent communicable diseases 5, R12, and R13 from the east the facility treated 5	F3	324	DEPICIENCY)		7/19/07
	residents for a rash (R11, R14, R15, R2) precautions were d	n with Elimite on May 4, 2007 16, and R17) No isolation ocumented for these ctions were not nosocomial					

		IDENTIFICATION NUMBER:		IULTIP LDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		146045	B. WI	NG			C <b>1/2007</b>
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F 441	the facility's Infection follow-up document found in the clinical interview with E15 06-21-07 at 10:40A	ed on 05-25-07 according to on Control Log for May. No tation regarding the rash was I record for R11, confirmed by (Licensed Practical Nurse) on	F	441			
	and skin scrapings Elimite cream was one time only with the rash or need fo included on the Ap control log, confirm (Administrator) on c currently has a rec abdomen, back, an scratching himself E15 on 06-21-07 a same type rash sin on 05-04-07 then re treated with Perme	were done (negative results). applied to R5 on 05-04-07, no follow-up to the status of r re-treatment. This was not ril or May 2007 infection ed by interview with E1 06-21-07 at 1:30PM. R5 d raised rash on his arms, ad buttocks and was observed on 6-21-07. Per interview with t 10:40AM, R5 has had the ce April 2007. It cleared some eturned on 06-15-07. R5 was thrin 5% on 06-16-07. R5's ted with Hydrocortisone cream					
	revealed a red skin 05-03-07 with the p scraping to be done record, verified with Results were obtain 1:00PM by E5 sta R12 and R13 were cream one time on included on the fact Control Log, confirm	s (roommates) record review rash documented on obysician ordering a skin e. No lab results were in the n E5 (Registered Nurse). The ned per fax on 06-21-07 at ting both were negative. Both treated with Permethrin 5% ly on 05-05-07. This was not ility's May 2007 Infection med with interview with E3 Nurse) on 06-21-07 at					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

AND PLAN OF CORRECTION (		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 441	record to determine was observed on 00 slight red rash on h scabbed areas note interview on 06-21-itches and that she months.  4. On 06-20-07 the and 7 staff to have complaints of itchin rashes were treated 06-19-07 with Permon a June Infection scrapings were obtaconfirmed the rash physician's progres other 47 residents h 06-20-07. The facility and staff on 06-21-d Seven staff membered rash with itching positive diagnoses with treatments ord 06-19-07. All staff v The facility does not identify rashes and treatment, confirmed	the rashes had cleared. R12 at the rash lower arm with ad. R12 complained during an	F	141			
F9999	06-21-07 at 1:30PM FINAL OBSERVAT	IONS	F99	99			
	300.1210a) 300.1210b)6)	ATIONS					

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		146045	B. WIN	1G _			1/2007
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 210 EAST COLLEGE		
HELIA H	EALTHCARE OF ENE	RGY		E	ENERGY, IL 62933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	O Continued From page 12 300.3100d)2)		F99	999			
	Section 300.1210 0 Nursing and Persor	General Requirements for nal Care					
	and services to atta practicable physica well-being of the re each resident's con plan of care. Adequ nursing care and pe to each resident to personal care need	provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with aprehensive assessment and late and properly supervised ersonal care shall be provided meet the total nursing and is of the resident.					
		ring and shall be practiced on					
	assure that the resi as free of accident nursing personnels	y precautions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents.					
	Section 300.3100 G	General Building Requirements					
	d) Doors and Windo	ows					
	signal that will alert the building. Any ex- during certain perio device for part-time hour a day supervis required.	oors shall be equipped with a the staff if a resident leaves sterior door that is supervised as may have a disconnect use. If there is constant 24 sion of the door, a signal is not					
	These REGULATIO	ONS are not met as evidenced					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146045		(X2) M A. BUI		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		146045	B. WIN	IG		C <b>06/21/2007</b>	
NAME OF PROVIDER OR SUPPLIER  HELIA HEALTHCARE OF ENERGY				21	EET ADDRESS, CITY, STATE, ZIP CODE 10 EAST COLLEGE NERGY, IL 62933		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	interviews, the facilisupervision for 1 of as a wander-risk for attempts to elope from the facility identifier for elopement that it device. R1, who is decision making, at requires staff assist an unsteady gait, lewithout staff's known the street of a residual abrasions to both k.  The facility failed to assures supervision door alarm sounds alarms are operationall was not operated hall was no	ion, record review, and ity failed to provide adequate 2 sampled residents identified relopement and with previous rom the facility (R1).  Id 18 current residents at risk wear an electronic monitoring cognitively impaired for trisk for elopement, and who tance with ambulation due to left the facility on 06-05-07 yledge. R1 was found lying in lential area. R1 sustained linees from a fall.  In implement a system that in of the exit doors when the land assures that all door lonal. The front door alarm on C lional when checked on limits.  In resident admitted to the limits with diagnoses that include: It Loss, Dementia, Depressive lool Abuse according to the listory and Physical dated latric assessment dated latric assessment dated latric assessment, executive	F99	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146045			(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		146045	B. WING			C <b>06/21/2007</b>		
NAME OF PROVIDER OR SUPPLIER  HELIA HEALTHCARE OF ENERGY			•	2	REET ADDRESS, CITY, STATE, ZIP CODE 210 EAST COLLEGE ENERGY, IL 62933			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F9999	required). R1 was a limited assistance of assistance for trans with one person as off the unit. The ME Elopement Assessing identify R1 as an element of the unit. The ME Elopement Assessing identify R1 as an element of the unit. The ME Elopement Assessing identify R1 as an element of the unit. The facility in the factor on the unit of the factor of th	ecision poor cues/supervision also assessed to require of two-plus person physical offers and total dependence sistance for locomotion on and OS and facility's initial ment dated 03-16-07 did not	F99	999				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	146045		B. WIN			C <b>06/21/2007</b>		
NAME OF PROVIDER OR SUPPLIER  HELIA HEALTHCARE OF ENERGY			1	2	REET ADDRESS, CITY, STATE, ZIP CODE 210 EAST COLLEGE ENERGY, IL 62933			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F9999	According to E7's in completed when Renoted on both of Relectronic monitoring right wrist and sour through the front dowith neurological chall door alarms were and R1 was placed by staff. R1's electrout of 5 times where interview with E7 or electronic device where approximately 3:16 the street at 303 Br. Upon Z2's arrival at flat in the street in stresponded to Z2 the could not walk. An atold Z2 that he had Chicago to Alabam bicycle. R1 knew his was not aware of his residence.  A search of the are approximately 100 driveway on Ford sthat R1 had crawlet the grass. Z2 states knees, and it looked.	ge 15 facility according to E6. Interview, an assessment was a returned. Abrasions were a device was in place on his aded when he returned for on A Wing. An assessment mecks was done on R1 by E7.  The checked upon R1's return, on 15 minute location checks onic device failed to sound 3 a tried at the door according to a 106-13-07 at 9:16AM. A new has placed on R1 by E7.  The control of the cont	F99	999				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146045			(X2) M A. BUI		TIPLE CONSTRUCTION  NG	(X3) DATE SU COMPLE		
		B. WIN	1G _		C <b>06/21/2007</b>			
NAME OF PROVIDER OR SUPPLIER  HELIA HEALTHCARE OF ENERGY				2	REET ADDRESS, CITY, STATE, ZIP CODE 210 EAST COLLEGE ENERGY, IL 62933			
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F9999	and had an electror right wrist. Z2 had facility and ask if the facility and ask if the facility was unaward facility was unaward facility at that time, per ambulance, and alarm sounded whe facility.  E7 was interviewed stated R1 was up a eloped. He talked to sick wife. This was and dressed at night E9 stated on 06-12 wanders in the halls doors frequently se interview with R1 of worked the night shows system and usually E3 (Licensed Pract Coordinator) was in 11:40AM. The facilithistory of night shift This was not includidentify times and a elopement, which we R1's care plan date elopement and war approaches but doe approaches but doe approaches as R1 elopement. The cut the 15 minute wher monitoring device as	ed in pants, shirt, and shoes nic monitoring device on his the police dispatcher call the ey were missing R1. The e R1 was missing from the R1 was returned to the facility of the electronic monitoring en R1 was brought back in the R1 was broug	F99	999				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146045		(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WIN	1G _		C <b>06/21/2007</b>		
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F9999	According to the we 06-05-07 the weath a high of 82 degree no precipitation.  R1 was interviewed was oriented to per facility in Chicago, current residence. If at night recently an something to eat. R wheelchair when he grass was slippery, street to get help. Fitime, he hurt his left stated he was "scaltime." R1 was not as ditches, but state of a car.  According to interving: 16AM, R1 would hazards and would where he resides.  The Helia Healthca East College Street is one block east of Route IL 148 (Persa a busy two-lane bla and truck traffic obsole-14-07. The road present on either si across the street to College Street, and	on 06-13-07 at 11:40AM	F99	999			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUBBLIED/CLIA

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		146045	B. WIN	1G _			C 1 <b>/2007</b>
NAME OF PROVIDER OR SUPPLIER  HELIA HEALTHCARE OF ENERGY				2	REET ADDRESS, CITY, STATE, ZIP CODE 210 EAST COLLEGE ENERGY, IL 62933	00/2	1/2007
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	street in a residenti park. In a wheelch block east on Colle blocks on Front Str block on Front Street. Tucker street, and past three houses. the street in front of Brenda Lane. Seve bordering College,  Z1 (physician) state 06-18-07 at 9:50AM Diagnosis, is confunursing home. Z1 safety hazards nor unsupervised.  According to a prev 05-06-07 at 11:45A facility and fell in the his head and receivate nose and forehous and	_	F99	999			

NAME OF PROVIDER OR SUPPLIER  HELIA HEALTHCARE OF ENERGY  STREET ADDRESS, CITY, STATE, ZIP CODE  210 EAST COLLEGE  ENERGY, IL 62933  (X4) ID  PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  C  06/21/2007	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146045			(X2) M A. BUI		FIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  HELIA HEALTHCARE OF ENERGY   STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST COLLEGE ENERGY, IL 62933   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F9999  Continued From page 19 apparent injuries (no mention if the door alarm or electronic monitoring device was working).  During the initial tour on 06-11-07 at 10:57AM with E3, the door buzzer alarm on the C Hall front door did not sound or light up at the nurses station when opened. According to interview with E5 (LPN on C hall) on 06-11-07 at 10:55AM, the alarm had not sounded or lit at the nurses station								
F9999  Continued From page 19 apparent injuries (no mention if the door alarm or electronic monitoring device was working).  During the initial tour on 06-11-07 at 10:57AM with E3, the door buzzer alarm on the C Hall front door did not sound or light up at the nurses station when opened. According to interview with E5 (LPN on C hall) on 06-11-07 at 10:55AM, the alarm had not sounded or lit at the nurses station  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COMPLET TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)					2	210 EAST COLLEGE		1/2001
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All exit doors in the facility are equipped with an electronic monitoring alarm signal that must be coded off at the door with a keypad before it ceases to sound for residents wearing the electronic monitoring bracelets. All doors also have a low sounding buzzer alarm that sounds only when the door is opened and quits when the door is closed. This alarm does not require staff to turn off the alarm.  Per interview with E7 on 06-12-07 at 9:16AM per phone, E7 stated the open door buzzers are not always heard by staff when they are in residents' rooms as the buzz is a low frequency and sounds like the call light buzzer. Staff do not always respond to the door buzzer as it sounds often, stated by E7.  E11 (Certified Nursing Assistant) also agreed the door buzzer sounds when the exit doors are opened and the buzzer sounds are not always heard when staff are in a resident's room or in the break room according to interview on 06-13-07 at 10:00AM per phone.  (A)	F9999	apparent injuries (nelectronic monitorir  During the initial too with E3, the door be door did not sound station when opened E5 (LPN on C hall) alarm had not sound since she came in a All exit doors in the electronic monitorir coded off at the doc ceases to sound for electronic monitorir have a low sounding only when the door door is closed. This to turn off the alarm  Per interview with E phone, E7 stated the always heard by state of the call light burespond to the door stated by E7.  E11 (Certified Nurs door buzzer sounds opened and the bust heard when staff ar the break room according to the door according to the door stated by E7.	or mention if the door alarm or any device was working).  For on 06-11-07 at 10:57AM suzzer alarm on the C Hall front or light up at the nurses ed. According to interview with on 06-11-07 at 10:55AM, the aded or lit at the nurses station at 7:00AM.  Facility are equipped with an any alarm signal that must be or with a keypad before it residents wearing the any bracelets. All doors also also buzzer alarm that sounds is opened and quits when the salarm does not require staff in.  For on 06-12-07 at 9:16AM per the open door buzzers are not aff when they are in residents is a low frequency and sounds zer. Staff do not always repure buzzer as it sounds often,  sing Assistant) also agreed the salarm the exit doors are zer sounds are not always re in a resident's room or in cording to interview on the propose.	F99	999			