STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145876	A. BUILDING _____ B. WING _____	C 08/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF URBANA	907 NORTH LINCOLN URBANA, IL 61801

(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 323	Continued From page 11 ~~system was functioning again.~~	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.1210 a) 300.1210 b)6) 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 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. b) General nursing care shall include at a minimum the follwoing 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. These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to provide effective supervision to one (R43) of 4 residents sampled for elopement behaviors. R43 was agitated and facility staff failed to increase necessary	F9999		

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F9999	Continued From page 12	F9999		

supervision. Also, facility staff turned off a window alarm system that could have alerted them to R43's exit out of a window. This allowed R43, a severely cognitively impaired resident, to leave the facility without staff knowledge at night and to cross, unattended and unsupervised, a very heavily traveled city street.

Findings include:

According to a facility Incident Report dated 7/31/07, "On 7/30/07 at approximately 9:45 PM, resident (R43) left the building through a window that he opened..."

An admission inquiry form dated 7/18/07 showed the facility was aware before R43 was admitted that he was an elopement (leaving the building unnoticed) risk. The form, titled with R43's name, stated as the resident's diagnoses, "...Alzheimers, Exit Seeking..."

The facility "Admission Assessment" form dated 7/24/07 (the date of R43's admission) confirmed to facility staff that R43, "...Wanders (and is an) "elopement risk..."

A communication from the facility Social Services Director to all Departments, including nursing indicated, "...(R43 is an) Elopement Risk...Loves Outside..." The words "Loves Outside" are double underlined.

R43 continued to show behaviors of exit seeking during the six days between admission day and the day he eloped. Nurses note dated 7/24/07 at 8:30 AM stated, "...Resident oriented to self. Exit seeking. Combative with CNA (Certified Nursing Assistant) during care. Refusing to follow

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F9999	Continued From page 13	F9999		

directions..." A nurses note dated 7/30/07, the day before R43 eloped, stated, "...Res (resident) cont. (continues) exit seeking..."

E1, Administrator, on 8/3/07 at approximately 1:00 PM indicated R43 had eloped from the building. E1 stated, "...yes, he got out - he went out the window. The windows are alarmed but someone had shut the alarm off. No one will admit to doing it. The previous Administrator allowed staff to turn the alarms off on nice days and open the windows. When I came in right after the resident (R43) eloped, the window was wide open and the alarms were not on..."

E12, CNA, on 8/7/07 at approximately 12:00 PM stated R43 had an episode of agitation just before he eloped. E12 stated, "I was working a double shift the night (R43) got out. I was working 200 wing - that is the locked unit. (R43) had become very agitated and had been pulling on other residents. He was going up and down the hallway saying he was going home....It was hard to redirect him. Around 9:20 PM the activity escalated and he was squeezing the hand of one of the female residents. (A staff member left the unit) walked over to get the nurse. The nurse came over, it took her about 10 or 15 minutes to come over. She (the nurse) said she would have to look in his chart. She looked in his chart. We started doing rounds (going into residents' rooms checking on them and changing their briefs if incontinent) about 9:30 PM. About 15 minutes later we went to look for (R43) to change him. I did not see him. I started walking down the hallway, looking in the dining room and in the T.V. room - he was not there. I opened room 201 (the first room) and noticed the window was open and the screen was out. I was shocked. We started

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to search."

E14, CNA on 8/3/07 at approximately 2:00 PM indicated R43 did not have safety awareness and should not be outside alone. E14 stated, "...he (R43) is not aware of his surroundings, he would not be safe outside, alone..."

E10, CNA on 8/7/07 at approximately 3:50 PM confirmed R43 was found outside away from the facility. E10 stated, "...I was working 7/30/07, the night (R43) got out. I was one of the CNA's that found him. I went down Fairview to the fairground. We (E10 was one of two CNA's that were searching together) were at the fairground. We started back to the facility and (R43) was coming toward us (walking away from the facility). He got out about 9:45 PM and we found him at about 10:00 PM or a little after. He is not safe to be outside by himself. I did not know the window alarms were shut off. He was found on the sidewalk. He had tried to get out before - since he's been here (at the facility) he has been trying to get out..."

E13, Licensed Practical Nurse, (LPN) indicated on 8/7/07 at approximately 11:00 AM that R43 did not know where he was going. E13 stated, "...I asked him (R43) where he was going (after he was returned to the facility) but what he said did not make any sense. I would say he should not be outside by himself - he would need assistance. I was under the impression the windows were locked. I did not know they were supposed to be alarmed. An alarm did not sound (when R43 got out)..."

Interview with Z5, R43's wife and Healthcare Power of Attorney, on 8/3/07 at approximately

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1:45 PM showed R43 was placed in the facility because family were concerned he was not safe. Z5 stated, "...yes I was concerned about (R43's) safety. He had gotten away from home before. I work 2nd shift and had relatives staying with him. He would get away from them. The police brought him home a couple of times. That is why I put him in the nursing home - because I was worried and couldn't watch him..." In the same interview Z5 demonstrated R43 did not execute an intent to go home as the purpose for his elopement from the facility. Z5 stated, "...we live in the opposite direction from where they found him. So if he was going home he was going the wrong way."

An attempt to interview R43 on 8/3/07 at approximately 1:20 PM was unsuccesful. R43's speech was disoriented, disordered, disorganized, and not easily understood. He could not express a thought that was coherent or that the listener could follow.

Measuring the distance from the facility to the fairgrounds by automobile odometer, on 8/9/07 showed the distance to be approximately 3/10 of a mile.

Observation of the main street in front of the facility showed the street to be a four lane busy thoroughfare with a speed limit of 30 miles per hour. Observation confirmed R43 would have had to cross this street to get to the fairgrounds.

(A)