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	145753	A. BUILDING _____ B. WING _____	C 02/28/2008

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F 323	Continued From page 8 actions to remove the immediate jeopardy: 1. On 2/4/08 at approximately 9:50 p.m. R1 was returned to the facility and after reassessment, an electronic monitoring device was placed on the resident. This was completed by the Administrator. 2. On 2/4/08 all direct-care and nursing staff present were inserviced by the Administrator on the Missing Persons Policy, Wandering Residents Policy and Elopement Procedures for missing residents. 3. On 2/4/08 a 1 to 1 inservice education was held with E5, RN (in charge of the elopement search) by E1 Administrator, in regard to elopement protocols and notification of the Administrator and Director of Nurses in a timely manner. 4. On 2/13/08 a mandatory all-staff inservice on the Missing Persons Policy, Wandering Residents Policy and Elopement Procedures for missing residents was given by the Administrator.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a	F9999		

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F9999	Continued From page 9 Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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. These regulations are not met, as evidenced by the following: Based on observation, interview and record review staff failed to implement a timely and effective search following activation of an exterior	F9999		

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F9999	Continued From page 10	F9999		

door alarm, indicating an unwitnessed exit by one of one sampled resident, R1. R1 left the building without supervision and was not located for at least 95 minutes.

Findings include:

According to the medical record face sheet, R1 was admitted to the facility on 1/17/08 with diagnoses that included Alzheimers Dementia, Chronic Obstructive Pulmonary Disease (COPD), Gait Ataxia, and Parkinson's Disease.

According to the admission assessment dated 1/31/08, R1 has long and short term memory problems with moderate cognitive impairment and poor decision making skills. R1 is also assessed as being ambulatory, requiring staff assistance to maintain standing balance, and as having a limited range of motion with partial loss of voluntary movement of both legs. Review of the assessment also showed that R1 is at high risk for falls, takes psychotropic medication and has an unsteady gait. Staff also documented on the assessment that R1 displays behaviors of wandering daily. According to the Activities of Daily Living Resident Assessment Protocol dated 2/3/08 staff documented, "Ambulatory with assist but is slow. Has diagnosis of Parkinsons."

During interview with E5, Registered Nurse (RN) on 2/14/08 at 1:43 p.m., she stated that R1 walks slow and she did not believe that R1 could have gone too far. During interview on 2/19/08 at 4:40 p.m. with E12, CNA, she also stated that R1 walks real slow. Observation on 8/19/08 at approximately 11:00 a.m., R1 was observed walking in the main area around the nurses station. R1 walked very slow with an almost

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F9999	Continued From page 11 shuffling gait. The Care Plan dated 1/31/08 identifies the following problem, "Res. (resident) is very restless, wandering aimlessly in halls...." The Care Plan directs staff to monitor R1 with 15 minute checks and document this on the Resident Location Monitoring form. On the Accident/Incident Report dated 2/4/08 at 8:15 p.m., E5, RN documented, "At approximately 8:15 p.m. I was notified by (Certified Nurse Aide) CNA (E9) that (R1) is missing. Room to room search was initiated and so was the outside perimeter immediately. At about 9:10 p.m. 911 called to report missing person. At 9:15 p.m. call was made to Administrator to notify of incident. Police officer arrived at the facility at about 9:25 p.m. and got the resident's description and circumstances that happened. Search continued outside the perimeter till resident was found at about 10:15 p.m. " According to the Investigation of Event written on the backside of the Accident/Incident Report, E5, RN wrote: "Observed resident missing 15 minutes after last positive check on his location. Room to room search initiated and when resident could not still be accounted for - search on outside perimeter initiated. Administrator notified. After perimeter search (initial) was not successful - 911 called to report missing person. Outside perimeter search continued until resident was located, brought back to facility and assessed...." The facility policy and procedure on "Missing Residents" states "Should an employee discover that a resident is missing from the facility, he/she	F9999		

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F9999	Continued From page 12 should: Make a thorough search of the building(s) and premises. If the resident is not located within 15 minutes, the unit Charge will report the incident to the Shift Supervisor/Director of Nursing who will direct additional staff to search the premises outside the facility. If immediate search fails to locate resident, the Administrator will be notified. The Director of Nursing and the Administrator will determine the need to report incident to the local Police department with a complete description of the resident and what he/she was wearing." On 2/14/08 at 1:43 p.m. E5, RN and Charge Nurse for the wing on which R1 resides stated that she became the nurse in charge of organizing the search on 2/4/08 at 8:15 p.m. E5, RN stated, "I did not call the Director of Nursing within the first 15 minutes as required by the facility policy because I did not expect (R1) to wander off the premises. I did not want to alarm anyone and felt the resident was inside the building. I also thought (E11) the DON was on her way into the facility." E5 also stated, "The weather was windy and not cold. It was a clear night." During interview with E11, DON, on 2/20/08 at approximately 9:51 a.m., she stated that if staff had called her she would have instructed E5, Charge Nurse to send more staff outside around the perimeter of the building, and she would have immediately called the Administrator before leaving home. E11 stated, "I also would have assisted in the search when I got to the facility." E11 stated that she lives about a 2 minute drive from the facility. E11 stated that she would have called the Police sooner. E11 stated that she was not notified of the elopement and arrived at the	F9999		

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F9999	Continued From page 13 facility at approximately 10:05 p.m. on 2/4/08. On 2/19/08, E3 demonstrated the facility exterior door alarm system which has a two part alarm when the door is opened. There is a shrill toned alarm which sounds when the door is opened and must be shut off at the door. In addition, there is a central facility wide door alarm system which sounds and gives an audible location at the annunciation panel stating which door was opened. This annunciation panel is located at the nurses station and may be turned off at that point. In addition, the exterior doors also have an alarm which is triggered when a resident who wears an electronic monitoring device walks through the door. During interview on 2/14/08 at 3:50 p.m. E9, CNA, assigned to provide supervision and care for R1 on 2/4/08, stated, "the last time I saw (R1) he was sitting down in a chair at the nurses station at 8:00 p.m." E9 stated that he then showered R7 and after coming out of the shower he again checked on R1. E9 stated, "I showered (R7) and when I came back out from the shower, I noticed that (R1) was not there. I began searching for (R1) in his room, in the dining room, by the nurse's station. I asked (E8 RN) if she had seen (R1). At that same time, (E8) was on her way to shut off a door alarm at the nurses station. The alarm showed that the 'Smoke Door and the West Wing door were opened.' (E8) told me to go check the West Wing door. I looked out the West Wing door and did not see anyone and was coming back up the hallway when (E8), told me to go outside the door and look around for (R1). I returned to the West Wing door and went outside to the parking lot, the bus stop and walked around the perimeter of the building, and	F9999		

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F9999	Continued From page 14 returned inside to help with the room search." During interview on 2/14/08 at 4:25 p.m. E8, RN stated, "the alarm was sounding and the audible alert was 'Smoke door open. West Wing door Open.'" E8 said, "I sent (E9,CNA) to check the West Wing door. I walked behind (E9) down the West Hall." E8 asked E9, "Did you go outside to check for (R1)?" E9 stated that he looked out the door only. E8, then stated, "I told (E9), you have to go outside, go back, go out the West Wing door, and check that area outside the building." E8 also stated, "I went outside of the Smoke Door and covered the entire perimeter of the building circling back and entering back through the front entrance." According to E8, after she reentered the building, she joined other staff for the inside search of the building. On 2/20/08 at 4:08 p.m., interview with another RN, E13, who was on duty at that time, showed that she remained in the building with two CNAs to take care of the residents while other staff went outside to search. E13 recalled that (E5, Charge Nurse) went to the North Building and (E8, RN) went a different way. E13, stated "there was no specific route specifying where each staff member went to look. No specific plan. Just everyone was looking for the resident to find him." E13 stated, "the 3 nurses were looking inside the facility when the police came." E13 stated, "(E5), Charge nurse checked inside and went outside then others also went out. No one was organizing where staff were going. Staff's main concern was to think of places where the resident might have gone and go out and look there. Everyone was wanting to find the resident."	F9999		

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F9999	Continued From page 15 During interview on 2/4/08 at 9:45 a.m., E10, CNA said she reported to work on 2/4/08 before the beginning of her shift at 10:00 p.m. E10 stated the third shift nurse asked her to "check rooms with (E7, CNA)." E10 said she asked E7, "has anyone checked the creek area, a small wooded area?" E10 stated she and E7 then went outside to look there for R1. E10 stated, "I called (R1's) name and thought I heard something. I thought about crossing the road but there was too much traffic. It was then that I looked back toward the ravine. I looked back from the top of the road and could see the resident standing up. I ran down there and helped the resident walk up the incline." E10 covered R1 up with her coat. E10 said R1 did not appear to be hurt and that R1 had muddy shoes. E10 stated she walked R1 back on the side of the road on a graveled area stating that R1 was alert, walking and talking to staff. According to the Nurse's Notes, upon arrival back to the building R1's temperature was 95.4 degrees F.(axillary). R1's temperature taken on 2/5/08 at 6:00 a.m. was 96.7 degrees F. and at 2:00 p.m. that same day it was 98.2 degrees F. (axillary). Another Nurse's Note entry at 10:30 p.m. on 2/4/08 states, "....Resident resting and requested (extra) blanket (due to) feeling cold." On 2/19/08, E3, Maintenance Supervisor walked the pathway of R1 to take this surveyor to the place where staff located R1. E3 exited through the West Wing door, across the parking lot and crossing the bus stop to the south-west property line which was approximately 300 feet from the West Wing door. E3 stated that according to the muddy foot prints that E1, Administrator followed on the night of the incident, they concluded that R1 walked along a fence on a level piece of	F9999		

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F9999	Continued From page 16 ground before walking up an incline to an asphalt driveway. The area was level, however, the ground was very rough to walk on. The next area that R1 entered was down a 6 to 8 foot area with an approximate 60 degree incline which then leveled off for approximately another 60 feet straight ahead, to an approximate 3 foot area with a 45 degree incline to step down to an approximate 2 foot level area. E3 stated this was the spot where R1 was found. E3 stated that this area was approximately 9 to 10 feet below the level of the street. There was a ravine with a small stream that appeared to have about 1 to 3 inches of water. Looking straight ahead there appeared to be no point of egress. The incline on the other side of the water was too steep to walk on. R1 was located at approximately 9:50 p.m. According to an Internet based hourly weather data resource for the area, the outside temperature was 55 degrees Fahrenheit (F) with 100 % humidity. According to the facility summary report R1 was wearing a burgundy sweatshirt, navy blue sweat pants and black shoes. When questioned, E1 stated that (R1) was not wearing any outer clothing or hat. On 2/14/08 at approximately 1:00 p.m., E1, Administrator stated that R1 told her that he was on his way to visit his Power of Attorney (POA). Review of the medical record showed that the POA resides in Springfield, Illinois. The road that runs parallel to R1's path of exit is a two lane heavily traveled road that is one of the main north-east entrances to Danville. (A)	F9999		