STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E701	A. BUILDING _____ B. WING _____	R 05/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG MEADOWS	**1000 LONGMOOR SAVANNA, IL 61074**

(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 000}	INITIAL COMMENTS First certification follow-up survey to the survey of 3/6/08 A Partial Extended Survey was conducted.	{F 000}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to identify alternative approaches to keep a resident (R47) from displaying and acting on exit seeking behaviors. The facility failed to review and revise the resident's (R47) careplan with new approaches after a resident eloped from the	{F 280}		7/1/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

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{F 280}	Continued From page 1 building, into the facility's parking lot, on 4/20/08. This is for 1 (R47) of 9 residents reviewed. The example is: R47 is a 73 year old resident with the diagnosis of Dementia, according to the May 2008 Physician Order Sheet (POS). R47's Minimum Data Set (MDS) of 4/27/08 shows that the resident has short and long term memory deficits and makes poor decisions, requiring supervision. The MDS shows that she wanders on a daily basis. The MDS also shows that the resident does not know the current season, location of her room, staff names, and does not know that she is in a nursing home. An interview with R47 on 5/14/08 at 4:00 PM shows that the resident is not aware of the month, year, or who the president is. R47's Preadmission Screening and Resident Assessment, Elopement Potential of 4/14/08 shows that the facility identified the resident's wandering behavior and that she is an elopement risk. Nursing Notes document that from 4/14/08 to 5/3/08 the resident displayed elopement behaviors 11 times. The behaviors were going to the front door, wearing multiple layers of clothing, packing her suitcase, and attempting to go out the front door. On 4/16/08 (PM shift) documentation shows, "has attempted to elope several times between 4:30 PM and 6:00 PM. On May 20, 2008 at 2:03 PM, Nursing Notes states, "...After lunch noted resident out in front parking lot...".Nursing Notes for 5/3/08 written by E 33(RN) states, "Resident exited building at 5:15 PM with a visitor. Returned to building by staff.	{F 280}		

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{F 280}	Continued From page 2 (Alarm) pager did not indicate resident exiting...". Documentation does not show how long the resident was out of the building without staff knowledge. On 5/14/08 at 4:00 PM R47 was asked if she remembered leaving the building on 5/3/08 and walking to the park. The resident said that she did not remember. She said, "I left the building? I sure don't remember doing that, oh that's terrible." The resident's careplan for wandering was written on 4/29/08. Although the resident has made numerous attempts at eloping from the facility, the careplan was not revised with new approaches until the resident eloped from the facility, without staff knowledge, on 5/3/08. The resident was found by an off duty staff member 0.8 of a mile away. The Activity, Behaviors, and Mood careplan were written on 4/29/08 and have not been revised with different approaches and interventions.	{F 280}		
{F 323} SS=J	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to supervise a confused resident (R47) who exhibited unsafe wandering	{F 323}		7/1/08

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{F 323}	Continued From page 3 behaviors and has a history of elopement. These failures resulted in R47 eloping from the facility on May 3, 2008 at about 5:45 PM. The resident was found by an off duty Certified Nursing Assistant (CNA) 0.8 miles away from the facility. The resident had to walk along a state highway where the posted speed limit was 45 miles per hour. There is also a river that crosses under the highway. These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 5/15/08. The Immediate Jeopardy began on May 3, 2008 at 5:45 PM, when R47 left the building unknown to facility staff. While the Immediate Jeopardy was removed on May 3, 2008 at 6:45 PM the facility remains out of compliance at a severity level 2 due to the need to evaluate the implementation of the new policies and procedures and care plan approaches for R47. This is for 1 (R47) of 3 residents reviewed with wandering behaviors. The example is: R47 is a 73 year old resident with the diagnosis of Dementia, according to the May 2008 Physician Order Sheet (POS). R47's Minimum Data Set (MDS) of 4/27/08 shows that the resident has short and long term memory deficits and makes poor decisions, requiring supervision. The MDS shows that she wanders on a daily basis. The MDS also shows that the resident does not know the current season, location of her room, staff names, and does not know that she is in a nursing home. An interview with R47 on 5/14/08 at 4:00 PM shows that the resident is not	{F 323}		

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{F 323}	Continued From page 4 aware of the month, year, or who the president is. Prior to R47 being admitted to the facility on 4/14/08, a hospital History and Physical (H&P)states that the resident's "lack of judgement is quite significant", and the resident had tendencies to wander away from home. R47's Preadmission Screening and Resident Assessment, Elopement Potential of 4/14/08 shows that the facility identified the resident's wandering behavior. Nursing Notes document that from 4/14/08 to 5/3/08 the resident displayed elopement tendencies 11 times. The behaviors included going to the front door, wearing multiple layers of clothing, packing her suitcase, and attempting to go out the front door. On 4/16/08 (PM shift) it is documented, "has attempted to elope several times between 4:30 PM and 6:00 PM. On 4/20/08 at 2:03 PM, Nursing Notes states, "...After lunch noted resident out in front parking lot...".Nursing Notes for 5/3/08 written by E 33(RN) states, "Resident exited building at 5:15 PM with a visitor. Returned to building by staff. (Alarm) pager did not indicate resident exiting...". The documentation for R47 does not show how long the resident was out of the building without staff knowledge. The resident's careplan for wandering was written on 4/29/08. Although the resident has made numerous attempts at eloping from the facility, the careplan was not revised with new approaches until the resident eloped from the facility, without staff knowledge, on 5/3/08. One of the interventions of the Wandering	{F 323}		

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{F 323}	Continued From page 5 Careplan is that the resident is on every 15 minute checks from 4:30 PM-10:00 PM. At all other times the resident is to be on every 1/2 hour checks. The Resident Check Log for 5/3/08 shows that the resident was last seen in the main dining room at 5:45 PM. The log does not show that the staff were aware of the resident's whereabouts until at 6:45 PM. The entry says that the resident is in her room. On 5/14/08 at 2:00 PM, E31 (Administrator) agreed that, according to the log, it does not appear that staff checked on the resident every 15 minutes from 5:45 PM until 6:45 PM. On 5/4/08 at 3:25 PM, E32 (CNA) said that during the time frame between 5:45 PM and 6:45 PM she was the only person on the floor. She said that when there is only one staff member on the floor, it is "a lot for one person to do". E32 said that she had heard that earlier in the day the resident had gotten out into the facility's parking lot. The facility's Incident Report of 5/3/08 states, "resident at 5:15 PM exited the building with a visitor, was returned/assisted back into the building by staff member...". The report does not say how long the resident was gone or where she was found. The resident's careplan of 4/29/08 addressing R47's wandering behavior shows that the resident wears an alarm watch. The watch was observed on the resident at all times during the survey. On 5/14/08 at 9:50 AM, E31 (Administrator) said that the watch that the resident wears is connected to the alarm system. E31 said that the alarm system is constantly "searching" for each resident who wears one of	{F 323}		

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{F 323}	Continued From page 6 the alarm watches. If the system does not detect the resident, the system sends a message to pagers stating that a resident cannot be detected. The pagers are worn by the Charge Nurses and the Certified Nursing Assistants. On 5/14/08 at 12:05 PM E33 (RN) said that on the evening shift of 5/3/08 she was R47's nurse. E33 said that the staff were not aware that the resident was gone from the facility until an off duty CNA (E34) brought the resident back. E33 said that the pagers did not alert staff that the resident was no longer in the building. On 5/14/08 at 1:15 PM, E34 (CNA) said that he was off duty and driving on the state Highway , by the park (0.8 mile from the facility). E34 said that he saw the resident walking. She had crossed the highway and was by the park. He said that he pulled over, told the resident to get in his car, and he would take her back to the facility. E34 said that she got into his car without difficulty. E34 said that R47 said that she was going home but she did not know where she was. E34 said that the facility staff were not aware that the resident had eloped from the building until he brought her back to the facility. On 5/14/08 at 4:00 PM R47 was asked if she remembered leaving the building on 5/3/08 and walking to the park. The resident said that she did not remember. She said, "I left the building? I sure don't remember doing that, oh that's terrible." On 5/15/08 at 4:00 PM the area where the resident was found was observed. The park is located on a state Highway, on the edge of town. The posted speed is decreased from 55 miles per	{F 323}		

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{F 323}	Continued From page 7 hour to 45 miles per hour. The roadway was observed to be heavily traveled. The area crossed from the park has approximately 10 feet of walking space before being in the road. On 5/15/08 at 9:50 AM, E31 said that when R47 eloped from the building, undetected, the pagers did not send out a page stating that R47 was not detected by the alarm system. E31 said that the resident must have gotten out of the building with a visitor, because the doors did not alarm when the resident left the building. He said that the alarm company was contacted to assess the cause for the pagers not alarming. E31 said that up until the incident of 5/3/08 the alarm system was checked for proper functioning weekly. On 5/15/08 at 2:00 PM, E31 was shown the entry in the Nurses Notes 4/20/08 at 2:03 PM which said that R47 was observed outside in the parking lot. E31 agreed that the alarm pagers must not have alerted the staff. The weekly Alarm System check sheets from 3/11/08 through 5/9/08 were reviewed. The check sheets show that on 8 out of 11 days some of the alarm pagers were not functioning. E31 (Administrator) was notified of an Immediate Jeopardy on 5/15/08 at 2:05 PM related to R47's elopement. The surveyor confirmed the facility took the following actions to remove the immediacy: 5/3/08 Resident returned to facility and staff did 1:1 supervision with the resident. Specific staff are assigned to complete these checks.	{F 323}		

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{F 323}	Continued From page 8 Resident condition assessed. Administration notified. Family & Physician notified. Administrators and Maintenance arrived and immediately contacted the Monitoring System Company regarding system failure and the pagers not receiving the page regarding a resident missing. Technical support was able to work on the system remotely to bring it back into a proper functioning state. A sign was placed on front door stating: Attention Visitors: Please do not allow others to follow you out the door. If someone asks you for the code or asks for assistance with the doors please direct them to staff. Thank you for your cooperation. Director of Nursing scheduled staff to provide 1:1 supervision with the resident through the remainder of the weekend. 5/4/08 Nurse noted that the system had an error again on Sunday Morning, elopement risk residents were immediately accounted for and administration was contacted. Residents on the Elopement Risk list were frequently checked during this time period to assure safety. The Monitoring System Technical Support was again contacted regarding system failure. Technical support was able to work on the system remotely to bring it back into a proper functioning state. Nurses then checked the system on a hourly basis to ensure proper functioning and technical support monitored the system remotely for a time to ensure proper functioning status. 5/5/08 The Alarm System company representative was here in the building to provide training on the	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 9 system and to review system upgrades that have been requested. Daily checks of the monitoring system and pagers has been implemented. Office staff and nurses continue to monitor the computer system on an hourly basis to ensure proper functioning. Staff doing 1:1 supervision with the resident are documenting on the check sheet. CNA staff will document resident checks when husband/friend are providing 1:1 supervision of the resident. Alarms are attached to the residen's and neighbors door when the resident is in room with 1:1 supervision being provided by spouse. This will alert staff if they are going to be out of the room. The CNA supervisorwas informed ofthe need to schedule staff to provide 1:1 supervision of the resident. 5/6/08 Chairs in the lobby were moved away from the front doors in order to encourage residents to mingle in the central part of the building. A couch was placed in the Recreational Therapy area to create more of an inviting living room setting. Pictures of new residents are posted for each department within the first few hours of admission. Prior to Dietary staff leaving for their shift, they are providing CNA staff assistance by closing the front lobby area for the evening and assisting residents to their rooms, the Recreational Therapy area, Media Room, etc. 5/13/08 Staff completing 1:1 supervision with resident and are documenting on behaviors.	{F 323}		

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{F 323}	Continued From page 10 5/14/08 A surveillance company has assessed the lobby area for a quote to install video surveillance cameras in the lobby with monitors for viewing at both nurses stations and in the break room. 5/15/08 Activity Desk placed in the resident's room with supplies for diversion (i.e. word search puzzles, paper, typewriter, etc.). Care Plans reviewed for residents on the Elopement Risk list. Nursing Shift Meetings were held to discuss resident safety. 5/20/08 Nurses Meeting is scheduled to review resident safety and supervision of residents. Residents on the Elopement Risk list are checked on following the supper meal each day by the nurse and documented on the 24-hour report. 5/22/08 The alarm system company will have the system enhancements installed. Elopement Policy & Procedure revised to reflect system enhancements. New Elopement Assessment tool will be introduced and utilized on all new admits quarterly, annually, and at times of a significant change of status. An all staff meeting is scheduled for today to educate staff on the revised Elopement Policy and Procedure and review of resident safety and supervision, related to elopement. By 5/31/08	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 11 All staff will be educated on the revised Elopement Policy and Procedure and review of resident safety and supervision, related to elopement.	{F 323}		
F 353 SS=D	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to have staffing on 5/3/08 to perform15 minute checks to monitor the whereabouts of a resident (R47) with Dementia. This failure resulted in R47 exiting the building without staff knowledge on 5/3/08. R46 was found, by an off duty staff member, 0.8 miles from the facility.	F 353		7/1/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG MEADOWS	1000 LONGMOOR SAVANNA, IL 61074

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F 353	Continued From page 12 This is for 1 of 9 residents reviewed. The example is: R47 is 73 year old resident with the diagnosis of Dementia, according to the May 2008 Physician Order Sheet (POS). R47's Minimum Data Set (MDS) of 4/27/08 shows that the resident has short and long term memory deficits and makes poor decisions and requires supervision. The MDS shows that she wanders on a daily basis. The MDS also shows that the resident does not know the current season, location of her room, staff names, and does not know that she is in a nursing home. Nursing Notes for 5/3/08 written by E33 (RN) states, "Resident exited building at 5:15 pm with a visitor. Returned to building by staff. (alarm) pager did not indicate resident exiting...". There is no documented time of how long the resident was out of the building without staff supervision. R47's "Wandering" care plan of 4/14/08 shows that the resident wears an alarm watch, which monitors the resident for exiting the building. The careplan shows that R47 is on 1/2 hours checks except between the hours of 4:30 PM and 10:00 PM, then the staff are to do visual checks on the resident every 15 minutes. The 15 minute and 1/2 Hour Check Log for R47 shows that the last time staff knew of the resident's whereabouts was at 5:45 PM when the resident was seen in the Main Dining Room. According to the log, the resident was next seen in her room at 6:45 PM. On 5/14/08 at 12:15 PM, E33 (RN) said that she was R47's nurse on May 3, 2008, when she	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E701	A. BUILDING _____ B. WING _____	R 05/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG MEADOWS	1000 LONGMOOR SAVANNA, IL 61074

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F 353	Continued From page 13 eloped from the building. E33 said that she was not aware that the resident had exited the building until an off duty Certified Nursing Assistant found the resident walking by a park, on Highway 64, 0.8 of mile from the facility. On 5/4/08 at 3:25 PM, E28 & E32 (CNAs) were interviewed. E32 said that during the time frame between 5:45 PM and 6:45 PM she was the only person on the floor. E32 said that when there is only one staff member on the floor, it is "a lot for one person to do".	F 353		
F 456 SS=E	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that the alarm system, which monitors the facility's exterior doors, was in good working order. This failure resulted in R47 eloping from the facility undetected on 5/3/08 on the PM shift. This has the potential to affect all 11 residents (R6,10,12,16, & R47-53) who have been identified by the facility as confused wanderers. The example is: R47 is a 73 year old resident with the diagnosis of Dementia, according to the May 2008 Physician Order Sheet (POS). R47's Minimum Data Set (MDS) of 4/27/08 shows that the resident has short and long term memory deficits	F 456		7/1/08

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	14E701	A. BUILDING _____ B. WING _____	R 05/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG MEADOWS	1000 LONGMOOR SAVANNA, IL 61074

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F 456	Continued From page 14 and makes poor decisions, requiring supervision. The MDS shows that she wanders on a daily basis. The MDS also shows that the resident does not know the current season, location of her room, staff names, and does not know that she is in a nursing home. On May 20, 2008 at 2:03 PM, Nursing Notes states, "...After lunch noted resident out in front parking lot...".Nursing Notes for 5/3/08 written by E 33(RN) states, "Resident exited building at 5:15 PM with a visitor. Returned to building by staff. (Alarm) pager did not indicate resident exiting...". The resident's careplan of 4/29/08 addressing R47's wandering behavior shows that the resident wears an alarm watch. On 5/14/08 at 9:50 AM E31 (Administrator) said that the watch that the resident wears is connected to the alarm system. E31 said that the alarm system is constantly "searching" for each resident who wears one of the alarm watches. If the system does not detect the resident, the system sends a message to pagers stating that a resident cannot be detected. The pagers are worn by the Charge Nurses and the Certified Nursing Assistants. E31 said that on May 3, 2008 at about 5:45 PM when R47 eloped from the building, undetected, the pagers did not send out a page stating that R47 was not detected by the alarm system. E31 said that the resident must have gotten out of the building with a visitor, because the doors did not alarm when the resident left the building. He said that the alarm company was contacted to assess the cause for the pagers not alarming. E31 said that up until the incident of May 3, 2008 the alarm system was checked weekly for proper functioning.	F 456		

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F 456	Continued From page 15 A communication from the alarm system company on 5/3/08 states, "...It looks like the system was recording all events properly, however (E31) reports that the system didn't send a page when the resident disappeared from system communication. The system said that it was paging properly but there is no way to be sure at this point especially as there may be some kind of computer hardware error...Database needed some minor maintenance so I did that while checking everything out...". The weekly Alarm System check sheets from 3/11/08 through 5/9/08 were reviewed. The check sheets show that on 8 out of 11 days some of the pagers were not functioning.	F 456		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.1220b)3) 300.2210b)2) 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.	F9999		

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F9999	Continued From page 16 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.2210 Maintenance b) Each facility shall: 2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems. Section 300.3100 General Building Requirements d) Doors and Windows	F9999		

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F9999	Continued From page 17 2) All exterior doors shall be equipped with a signal that will alert the 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 not required. These regulations are not met, as evidenced by the following: Based on observation, interview, and record review the facility failed to supervise a confused resident (R47) who exhibited unsafe wandering behaviors and has a history of elopement. These failures resulted in R47 eloping from the facility on 5/3/08 at about 5:45 PM. The resident was found by an off duty Certified Nursing Assistant (CNA) 0.8 miles away from the facility. The resident had to walk along a state highway where the posted speed limit was 45 miles per hour. There is also a river that crosses under the highway. This is for 1 (R47) of 3 residents reviewed with wandering behaviors. Findings include: R47 is a 73 year old resident with the diagnosis of Dementia, according to the May 2008 Physician Order Sheet (POS). R47's assessment of 4/27/08 shows that the resident has short and long term memory deficits and makes poor decisions, requiring supervision. The assessment shows that she wanders on a daily basis. The assessment also shows that the resident does not know the current season,	F9999		

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F9999	Continued From page 18 location of her room, staff names, that she is in a nursing home. An interview with R47 on 5/14/08 at 4:00 PM shows that the resident is not aware of the month, year, or who the president is. Prior to R47 being admitted to the facility on 4/14/08, a hospital History and Physical (H&P) states that the resident's "lack of judgement is quite significant," and the resident had tendencies to wander away from home. R47's Preadmission Screening and Resident Assessment, Elopement Potential of 4/14/08 shows that the facility identified the resident's wandering behavior. Nursing Notes document that from 4/14/08 to 5/3/08 the resident displayed elopement tendencies 11 times. The behaviors included going to the front door, wearing multiple layers of clothing, packing her suitcase, and attempting to go out the front door. On 4/16/08 (PM shift) it is documented, "has attempted to elope several times between 4:30 PM and 6:00 PM. On 4/20/08 at 2:03 PM, Nursing Notes states "...After lunch noted resident out in front parking lot...." Nursing Notes for 5/3/08 written by E33 (RN) state, "Resident exited building at 5:15 PM with a visitor. Returned to building by staff. (Alarm) pager did not indicate resident exiting...." The documentation for R47 does not show how long the resident was out of the building without staff knowledge. The resident's careplan for wandering was written on 4/29/08. Although the resident has made numerous attempts at eloping from the facility, the careplan was not revised with new approaches until the resident eloped from the	F9999		

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F9999	Continued From page 19 facility, without staff knowledge, on 5/3/08. One of the interventions of the Wandering Careplan is that the resident is on every 15 minute checks from 4:30 PM-10:00 PM. At all other times the resident is to be on every 1/2 hour checks. The Resident Check Log for 5/3/08 shows that the resident was last seen in the main dining room at 5:45 PM. The log does not show that the staff were aware of the resident's whereabouts until at 6:45 PM. The entry says that the resident is in her room. On 5/14/08 at 2:00 PM, E31 (Administrator) agreed that, according to the log, it does not appear that staff checked on the resident every 15 minutes from 5:45 PM until 6:45 PM. On 5/4/08 at 3:25 PM, E32 (CNA) said that during the time frame between 5:45 PM and 6:45 PM she was the only person on the floor. She said that when there is only one staff member on the floor, it is "a lot for one person to do." E32 said that she had heard that earlier in the day the resident had gotten out into the facility's parking lot. The facility's Incident Report of 5/3/08 states, "resident at 5:15 PM exited the building with a visitor, was returned/assisted back into the building by staff member...." The report does not say how long the resident was gone or where she was found. The resident's careplan of 4/29/08 addressing R47's wandering behavior shows that the resident wears an alarm watch. The watch was observed on the resident at all times during the survey. On 5/14/08 at 9:50 AM, E31 (Administrator) said that the watch that the	F9999		

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F9999	Continued From page 20 resident wears is connected to the alarm system. E31 said that the alarm system is constantly "searching" for each resident who wears one of the alarm watches. If the system does not detect the resident, the system sends a message to pagers stating that a resident cannot be detected. The pagers are worn by the Charge Nurses and the Certified Nursing Assistants. On 5/14/08 at 12:05 PM E33 (RN) said that on the evening shift of 5/3/08 she was R47's nurse. E33 said that the staff were not aware that the resident was gone from the facility until an off duty CNA (E34) brought the resident back. E33 said that the pagers did not alert staff that the resident was no longer in the building. On 5/14/08 at 1:15 PM, E34 (CNA) said that he was off duty and driving on the state Highway, by the park (0.8 mile from the facility). E34 said that he saw the resident walking. She had crossed the highway and was by the park. He said that he pulled over, told the resident to get in his car, and he would take her back to the facility. E34 said that she got into his car without difficulty. E34 said that R47 said that she was going home but she did not know where she was. E34 said that the facility staff were not aware that the resident had eloped from the building until he brought her back to the facility. On 5/14/08 at 4:00 PM R47 was asked if she remembered leaving the building on 5/3/08 and walking to the park. The resident said that she did not remember. She said, "I left the building? I sure don't remember doing that, oh that's terrible." On 5/15/08 at 4:00 PM the area where the	F9999		

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F9999	Continued From page 21 resident was found was observed. The park is located on a state Highway, on the edge of town. The posted speed is decreased from 55 miles per hour to 45 miles per hour. The roadway was observed to be heavily traveled. The area crossed from the park has approximately 10 feet of walking space before being in the road. On 5/15/08 at 9:50 AM, E31 said that when R47 eloped from the building, undetected, the pagers did not send out a page stating that R47 was not detected by the alarm system. E31 said that the resident must have gotten out of the building with a visitor, because the doors did not alarm when the resident left the building. He said that the alarm company was contacted to assess the cause for the pagers not alarming. E31 said that up until the incident of 5/3/08 the alarm system was checked for proper functioning weekly. On 5/15/08 at 2:00 PM, E31 was shown the entry in the Nurses Notes 4/20/08 at 2:03 PM which said that R47 was observed outside in the parking lot. E31 agreed that the alarm pagers must not have alerted the staff. The weekly Alarm System check sheets from 3/11/08 through 5/9/08 were reviewed. The check sheets show that on 8 out of 11 days some of the alarm pagers were not functioning. (A)	F9999		