STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145160	A. BUILDING ______ B. WING ______	C 10/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL CARE CENTER	555 WEST CARPENTER SPRINGFIELD, IL 62702

(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 3 of the 2nd floor stair well measured 12 feet from the door to the wall and the steps started at six feet. There are eight steps to the landing where R1 was found. On 9/26/08, at 11:40AM, an Immediate Jeopardy was identified to have begun on 9/24/08 when R1 went through an unlocked, unalarmed door on the second floor, tumbled down eight steps and received numerous injuries including a fractured orbit and a fractured C5 facet. On 9-26-08 at 11:50AM, E1 and E2 were informed of an Immediate Jeopardy. The facility took the following steps to remove the Immediate Jeopardy: 1. On 9/26/08, the facility called a door alarm company at 11:15AM to request a keypad and wander guard system on the door to the second door stairwell. 2. On 9/26/08, at 11:50AM, The facility implemented a door monitor around the clock (24/hr/day) to ensure resident safety. 3. On 9-27-08, at 10AM, a door alarm was installed on the door and monitored for another 8 hours to ensure it was functioning. 4. All doors were checked for functioning alarms on 9-26-08, 9-27-08 and 9-29-08 with no problems noted.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.1220b)3) 300.1230c)	F9999		

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F9999	Continued From page 4	F9999		

Section 300.1210 General Requirements for Nursing and Personal Care

a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 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

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F9999	Continued From page 5	F9999		

needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.1230 Staffing
c) It is the responsibility of each facility to determine the staffing needed to meet the needs of its residents.

These Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to identify that an unlocked door to the stairwell was a safety hazard. This failure resulted in harm to R1 who tumbled down the stairs in his wheel chair and obtained a right C5 facet fracture, a left superior orbital fracture, a laceration on the left forehead above the eye requiring sutures and multiple scrapes on the body.

Findings include:

Record review of R1's admission sheet shows R1 was admitted from the hospital to the facility on 9-11-08, with a diagnosis, in part, of Dementia and history of a hip fracture. Record review of facility Elopement Risk Assessment of 9-11-08 shows R1 was assessed as being a risk for elopement.

Interview with E1 (Administrator) and E2 (Director of Nursing) on 9-26-08 reflected R1 had an electronic monitoring device on while in the facility. They stated R1 also had a soft waist restraint while up in a wheel chair.

Nurses notes of 9-12-08 show R1's family had

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F9999	Continued From page 6 brought in a gait belt and requested R1 to be tied to his wheel chair. R1 was assessed for a soft waist restraint which was implemented on 9-12-08. R1's care plan of 9-16-08 states R1 has Dementia. He is noted to wander without purpose throughout the day. He uses a soft waist restraint while up for safety related to a long history of falls and his confusion. Nurses notes of 9-24-08 at 5:10 PM, state that R1 was sitting up in a wheel chair on the 2nd floor by the dietary entrance. At 5:15PM, it was reported that R1 was on the floor in the 2nd floor stairwell. R1 was laying at the bottom of the first flight of steps with his wheel chair tipped over and soft waist restraint was attached. R1 was laying on the left side of his face. R1's neck was supported and the soft waist restraint was removed and the wheel chair moved. R1 was not moved and was immobilized. A laceration was noted to the left head and left cheek. A pressure dressing was applied and wrapped with a flexible self adhering dressing. Multiple skin tears were noted to the right arm and left forearm. 911 was called for hospital transfer. Hospital History and Physical showed R1 was admitted on 9-24-08 after a tumble down the stairwell in wheel chair. Findings: Right C5 facet fracture that can progress into lamina as well as left superior orbital fracture. Multiple scrapes on the body. A laceration was sewn on the left forehead above the eye. Several scrapes on the body and shoulder. Laceration and bruising around left eye. The report stated R1 had on a collar for the C5 fracture. Interview with Z1 (R1's family member) on 9-26-08 reflected R1 had tried to wander from the	F9999		

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F9999	Continued From page 7 house in the past and they had to change the locks because he would try to get out. Interview with Z2 (Hospital Social Services) on 9-26-08 reflected that R1's injuries were not considered life threatening and they were looking for placement and expected him to be discharged in a couple of days. Z2 stated she was not sure how many sutures R1 had, but thinks it was five. Interview with E1 on 9-26-08 at 10:35AM, reflected the stairwell door was not alarmed for an electronic monitoring device and did not have any type of alarm on the door. E1 said after R1's accident on 9-24-08, they put up a sign on the door for people using the door to check and make sure no residents were following them out the door. Observation confirmed the door was not alarmed. Interview with E3 (Second Floor Charge Nurse), E4 (Social Services) and E5 (Dietary Manager) on 9-30-08 reflected they had never seen R1 try to open the exit door to the second floor stairwell. On 9-26-08 at 11:15PM, E6 (Maintenance Director) stated the measurements from the door of the 2nd floor stair well measured 12 feet from the door to the wall and the steps started at six feet. There are eight steps to the landing where R1 was found. (A)	F9999		