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	146068	A. BUILDING ____ B. WING ____	C 04/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY ACRES NURSING HOME	**19130 SUNNY ACRES ROAD PETERSBURG, IL 62675**

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F 323	Continued From page 11 Alarm was not sounding. Unaware if (R2) hit head. Sitting on floor in front of bed with back toward bed and wheel chair in front. Supervisor Investigation and Interventions: Make sure alarm on at all times when up." R2's care plan dated 1/13/09 under the problem of falls includes the intervention to use alarms in bed, recliner and wheelchair. E3 stated on 4/21/09 at 2:40 pm, " It is understood that the CNAs are to check that the alarms are on when the CNA goes into the room. There is no other investigation on that incident. There is no written policy." 3. R3's facility incident report dated 2/12/09 at 5:40 am notes that E31 (LPN) entered R3's room and found R3 sitting on the floor in front of the bathroom door. Pressure alarm on bed was on but not sounding. The follow up Implementation states, "Alarm replaced." On 4/24/09 at 10:10 am while lying on her bed with a doll R3 asked, "How do you like my boy they gave to me?" Regarding R3's fall E3 (ADON) stated at 2:40 pm on 4/21/09. "The alarms are checked on the night shift and if they are not working they are replaced. They may be working one hour before the fall but not when the fall occurs so it can't be certain that a malfunction is caught. There is no written policy. It is understood that the CNA check that the alarms are on when the CNA goes into the room."	F 323		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 12 LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1210b)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 following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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:	F9999		

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F9999	Continued From page 13 Based on observation, record review and interview, the facility failed to effectively supervise 1 of 26 residents identified to have wandering behaviors, R5. Staff failed to respond to and investigate all door alarms and failed to develop/implement additional means of supervision following initial attempts by R5 to leave the facility. R5 left the facility unsupervised, without staff knowledge and was found in the middle of a busy roadway. Findings include: At 3:08 pm on 4/21/09, R5 was observed 0.3 miles from the facility walking down the center of the southbound lane of a two lane country road veering toward the center line. R5 was motioning at oncoming vehicles to move over to the northbound passing lane. Three vehicles passed R5 from the north at that time. R5 was holding a plaid flannel article which was blowing in the very brisk and gusty wind. Two other vehicles passed R5 from the south. No speed zone sign could be found on the two lane country road except 0.7 miles north where it is posted speed zone ahead 30 miles per hour. This is heading away from the facility heading north. R5 was heading south where there were ditches on both sides of the road from 4 feet to about 7 feet in depth. In one area the road crossed over a creek of running water. This area was around 7 feet deep on both sides. Cornfields with corn stalks stubble and otherwise rough terrain were observed on both sides of the road. On the left at around 0.4 mile from the facility was a road leading to a lagoon, at 0.5 mile is an animal shelter, and at 0.6 mile on the right the road meets a railroad crossing. The crossing does not have warning lights. At 1.6 miles from the facility the road south meets a	F9999		

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F9999	Continued From page 14 state highway with 45 to 55 mile per hour speed zone. The road north meets an east/west state highway at 1.4 miles with a 45 mile per hour speed zone. Both highways are heavily traveled. E1 (Administrator) and E3 (Assistant Director of Nursing) were notified at 3:10 pm on 4/21/09 that an an elderly male in a ball cap had been seen in the middle of the road down from the facility. E1 stated, "We'll go see." E1 and E2 drove down the road, pulled over and stated, "It was (R5). He's new. He's been here before. We just got him back a day or so ago." On 4/22/09 at 8:45 am E1 stated that after R5 was returned all the door alarms were checked with R5's electronic monitoring bracelet and all were functioning. E1 stated, "The alarms were all working when (R5) went out." Nursing notes dated 4/21/09 at 12:50 pm note, "(R5) attempted to go out exits times 2 today." The next nursing note is 4/21/09 at 2:00 pm, "Restless and anxious, wandering to door and asking for a $300.00 check. Ativan 1 milligram given." Z4 (R5's Power of Attorney) on 4/22/09 at 11:10 am reported, "(R5) had never walked away from home but had gotten lost when driving his car. We had to take away his vehicle about a year ago. We put him in the home in February and he wanted to go home so badly that April 3rd we took him home. He cried the whole time because he thought mother would be there and she wasn't. Mother has been gone for sixteen years. We just brought him back there on the 20th of this month."	F9999		

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F9999	Continued From page 15 E20 (Dietary Aide) on 4/24/09 at 2:28 pm stated, "I told the CNA (Certified Nurse Aide) that when I took (R5) out to smoke at 11:00 am (on day of incident), (R5) tried to run away from me to the parking lot. (R5) said he wanted to find his blue truck. Then he tried to follow me outside to the laundry room, the exit that goes out back. I told the nurse then that he was real wobbly. I guess it was therapy I told. That was all between 11:00 am and 12:00 pm. The third time he tried to follow me into the break room. I last saw (R5) around 3:00 pm when (R5) headed up toward the front door and into (E1's) office looking for his $300.00." E15 LPN (Licensed Practical Nurse) at 1:50 pm on 4/22/09 reported, "(R5) went down to the exit and (E16 LPN) brought him back saying that my little man keeps trying to get out. I didn't really question it. I think he set off the alarm." On 4/22 at 2:03 pm, E16 responded regarding the nursing note documentation of attempted to exit times two, "(R5) actually went out the door yesterday morning. (E17 CNA) was in the next room. The second time (R5) just set off the alarm. After lunch (R5) was really fretful looking for a $300.00 check. Really determined. I don't know how or where he went out but I was confident that people were watching him. (R5) was here before, wanders a lot and talks about going home." E14 (CNA) at 1:25 pm on 4/22/09 stated, "I was going to break around 2:00 pm when I saw (R5) go out the front door. I got him before he got to the second door, so he wasn't out of the building yet when I brought him back in. Then after work, after 3:00 pm, I picked him up on the road down	F9999		

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F9999	Continued From page 16	F9999		

by the animal shelter. He didn't have a coat, but he did have a little flannel lap blanket that he was carrying."

"It was 2:45 pm or 2:50 pm, yesterday," E13 (RN Registered Nurse) stated at 2:50 pm on 4/22/09 "that three of us came in the (south) exit and saw (R5) wandering around the furniture in front of the door. (E28 LPN) was there and told us (R5) was trying to get out again and that he had already gotten out today."

At 3:05 pm on 4/22/09 E9 (CNA) was asked about R5's care plan interventions for wandering. E9 stated, "We just got him today. He doesn't have a care plan yet. No one gave us specific instructions." E10 and E11 (both CNAs) were also with E9 during this interview. E10 replied, "They just told us to stay with him after he fell today." E11 responded, "No one said that he had tried to go out yesterday. No one gave us any instructions for (R5)."

Z5 (R5's Primary Care Physician) stated on 4/28/09 at 12:45 pm, "No, he (R5) was not safe out there on the road. He hasn't been safe to be alone for a long time. He has burned down things with his cigarettes. He needs some one to keep him safe."

The electronic monitoring system door alarms were checked by E7, Maintenance at 11:00 am on 4/22/09. During the test at the south entrance, E7 set off the alarm. Z3 and Z7 (visitors) were standing and talking in the area. While the alarm was sounding, Z3 went to the door alarm box and attempted to reset the alarm. E7 stated, "Don't do that." Z3 stated, "I'm sorry, I do it all the time. I guess it is just a habit."

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E7 triggered the electronic monitoring system door alarm on the Dementia unit at 11:24 am on 4/22/09. An announcement was made to check the door. At 11:29 am, E8 (Maintenance Assistance) who had been standing at the nurses station outside the unit upon entrance, came into the unit. E8 stated, "The nurse told me to come in and see why the alarm was going off." E8 was asked if the protocol was to wait for someone to send them in. E8 stated, "Well, whoever is close is supposed to check."

During the alarm checks with E7, all doors were found to have both an electronic monitoring system triggered by a resident wearing an electronic monitoring system bracelet. This alarm has to be reset at the door. There is a second alarm that displays on a board at one nurse station. For the second alarm system, staff must put in a code on the alarm board to disarm and silence the alarm. Then it is reset by putting the code in again.

E1 was asked for a policy/protocol for door alarms and electronic monitoring systems on 4/22/09 at 10:05 am. E1 stated that there is no written policy and that it is just understood. He then proceeded to describe how it is done. "The alarm goes off. It is announced from the alarm system as to which door to check. Staff are to physically check the door and to announce on the intercom when clear." E1 stated that all staff are informed on orientation of how the procedure works. On 4/24/09 E1 did provide a written policy titled (Electronic Monitoring Device) Protocol (no date). Included was "Implementation: Signal devices are applied to either wrist by licensed staff. All staff are responsible for responding

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F9999	Continued From page 18 when the alarm is sounded. Nursing staff are responsible for checking the location and investigation of alarms." R5 was observed in the dining room of the Dementia unit on 4/22/09 at 1:30 pm. R5 had a slow and slightly unsteady gait, sitting down to rest at times. R5 continued to try to open the door to the hallway, which exits to the kitchen and also goes out of the building. He also tried the accordion doors to a separate area of the room on several occasions. R5 stated, "How do you get out of here"? R5 returned to the doors to pull on the handles attempting to go out. At 3:03 pm on 4/22/09 R5 was placed on a stretcher by Emergency Medical Technicians. E1 stated, "(R5) tried to go out a window. We put an alarm on the window. We are sending him for his behaviors." R5 has diagnoses including: Syncope and Collapse, Personal History of Falls, Dementia, Coronary Artery Anomaly and Stage III Chronic Renal Insufficiency as noted in the admission face sheet dated 4/20/09. Wandering Assessment dated 4/20/09 indicated that R5 required an (Electronic Monitoring System Bracelet) for monitoring wandering/elopement behaviors. History of wandering, capable of independent locomotion, ability to open a door, resistant to nursing home placement and Dementia were all marked YES on the assessment. Interim care plan dated 4/20/09 included (Electronic Monitoring System bracelet). R5's previous admission MDS (Minimum Data Set) dated 2/17/09 identifies R5 as moderately impaired in cognition. The MDS also identifies (R5) to hear in special situations only, to have	F9999		

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F9999	Continued From page 19 poor vision, an unsteady gait, required supervision of one person for ambulation on and off the unit and had a history of falls in the prior 30 to 180 days. History and physical dated 2/6/09 notes, "(R5) says he was walking from his kitchen to his bedroom the next thing he knows, found himself lying on the floor. He has Dementia. He was here in October for similar complaints and was felt to need 24 hour care at that time. It should be noted that 3 years ago, he actually burnt down his house and has likely been unsafe to live alone since that time. Impression: Syncope." Physician Order sheet for R5 dated 4/1/09 includes: Metoprolol Tartrate 25 mg (milligrams) daily an antihypertensive which may cause drowsiness, Ativan 1 mg was given at 2:00 pm, an antianxiety which may cause sedation, unsteadiness and weakness, Zoloft 50 mg a day, an antidepressant which may also cause dizziness. Midwest Climate Control noted the temperate at the nearest airport 54 degrees with winds strong at 21 to 29 miles per hour on 4/21/09 at 2:52 pm. (A)	F9999		