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	145987	A. BUILDING _____ B. WING _____	05/14/2010

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F 520	Continued From page 162 Findings include: On 04/28/10 at 1:00 p.m., E1 (Assistant Administrator) stated that she coordinates the facility's QA committee. E1 stated she really hadn't looked at the infection log that E 40 (Licensed Practical Nurse Infection control nurse) had provided for the QA meetings. E1 stated she was not aware that E40 obtained the criteria for the infection control logs solely from the antibiotic report from the pharmacy. E1 stated that the QA committee evaluated the current infections from the log provided, had not been looking back at previous months of logs. With a infection control log that did not include all infections, and did not identify organisms and without evaluating previous months the QA committee could not accurately identify the trends and patterns of infections. E1 stated that the QA committee did not review or discuss R21's elopement of 4/7/10 and did not review the facility's policies regarding elopement. E1 stated that the influenza and pneumococcal immunization program had been in place since before she (E1) came to the facility and the QA committee has not reviewed or discussed it in the 3 years that she has been at the facility. E1 stated that the facility had received a bulletin from a provider organization that addresses infection control for blood glucose monitoring, but E1 said that the facility's QA did not discuss or act on the issue. E1 stated that the facility's restorative nurse left employment on 03/12/10. E1 stated that the facility's QA committee has not met since then to	F 520		

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F 520	Continued From page 163 discuss how the facility is to provide for the restorative needs of the residents until the restorative nurse can be replaced. E1 stated that the previous restorative nurse was also the RN coordinator who signed and certified the Resident Assessment Instruments. E1 stated that this restorative nurse was overseeing other staff members who had input on the RAIs, but no one was overseeing that the RN coordinator's duties were completed. E1 stated that this nurse was also a member of the facility's QA team and did not bring the concerns of the RAIs to the QA committee. E1 stated that the facility does not pull up the QI QM (Quality Indicators & Quality Measure) reports for the QA committee to review and identify patterns and trends of the facility. On 04/28/10 at 7:10 a.m., Z1 (Medical Director) stated that he has been the facility's medical director for several years. Z1 states that he attends the facility's QA committee meetings monthly, but has "no major role" in development and implementation of the facility's policies. He states that he reviews the information that is brought to the committee by the facility's QA team members and facility policies are not always reviewed by the QA committee before they are put into place. Z1 also stated that no administrative staff had apprised him of the problems being identified with the current survey.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a)	F9999		

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F9999	Continued From page 164 300.1210b)6) 300.3240a) 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 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	F9999		

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F9999	Continued From page 165 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. These Regulations are not met as evidenced by the following: Based on observation, record review and interview, the facility failed to effectively supervise one resident identified to have wandering or elopement behaviors (R21) in a sample of 15. Staff failed to follow their own policy and procedure for missing residents. Staff failed to search the outside perimeter of the facility after a door alarm sounded and failed to account for all residents after the door alarm sounded. The facility failed to implement approaches developed after previous attempts by R21 to elope from the facility. R21 left the facility unsupervised, without staff knowledge, and was found with injuries, lying on a neighbor's driveway. Findings include: A Police report dated 04/07/10 documents that on 04/07/10 at 8:43 a.m., a 911 emergency call came in stating that a person was found lying on a driveway located on a street behind the facility. At 8:46 a.m., paramedics arrived and at 8:49 a.m., R21 was taken to the hospital by the paramedics. A hospital report dated 04/07/10 with time noted	F9999		

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F9999	Continued From page 166 as 9:15 a.m. documents that R21 was found on the ground/street. This report documents that R21 had a laceration and swelling to the left orbital area. R21 was released back to the facility on 04/07/10 with instructions from the hospital to monitor for increased confusion and to follow up with R21's physician on 04/08/10. An Incident/Accident facility report documents on 04/07/10 at 9:00 a.m. that R21, "had gone out through the D-hall door between 8:45 a.m. and 9:00 a.m., was found across the yards on Court street, and had fallen on a neighbor's driveway; causing an abrasion to the left eye." This facility has multiple halls which extend outward from a common nursing desk and dining/activity area. At the end of the halls (away from the common area and the nurse's station) are exit doors which are not equipped with (personal alarm bracelet) receivers. These doors exit to the outside of the facility. Audible alarms sound when the doors are opened. An investigation report dated 04/07/10 documents, "(R21) had left the facility out the D-hall door and walked across the back yard, into a neighbors drive and the neighbor stated (R21's) shoe broke causing (R21) to fall sideways. The neighbor called 911 and (R21) was taken to the hospital emergency room by the paramedics." The investigation further notes that R21 had been on 15 minute visuals (checks) and that the D-hall, back door, was alarmed and R21 had a "(personal alarm bracelet) on." According to the investigation report the facility had called the hospital and was told that R21 was sedated due to requiring supervision and testing.	F9999		

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F9999	Continued From page 167 A nursing assessment dated 04/07/10 documents R21 returned to the facility at 5:15 p.m. This assessment describes R21's left eye as dark blue in color, and notes a scrape on the right forehead. The assessment documents that R21 ambulated with a slow/steady gait, was non-verbal at that time but did open eyes and follow commands/verbal cues. R21 received oxygen set at two liters per nasal canula to assist in keeping R21's oxygen saturation rate at 90% or more. Nursing note dated 04/08/10 (2:00 to 10:00 p.m.) documents R21's right eye was open more than the left and left eye remained with discoloration. R21 remained non-verbal. During an interview with E40/LPN (Licensed Practical Nurse) at 3:15 p.m., E40 stated that on 04/07/09, E27 (Maintenance), had checked the D-Hall exit door that was alarming and did not see anyone outside. E40/LPN stated he did not check the alarming door since E27/Maintenance had. E40 finished the morning medication pass, and then went to the morning department head meeting. E40 stated that he did not go personally look for R21. E40 stated that shortly after the morning meeting had started, the police arrived at the facility and informed the facility that R21 had fallen on a neighbor's driveway. E40 stated that E21/Certified Nurse Aide (CNA) had been monitoring R21 and recording R21's whereabouts every 15 minutes. E40 stated that R21 frequently attempts to elope and has shown some decline in mental status the last couple of weeks. E40 demonstrated the D-Hall exit door alarm and verified that it does not alarm with a "personal alarm" bracelet; only the front door alarms if a resident with a (personal alarm) alert	F9999		

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bracelet attempts to leave the facility. When E40 opened the D-Hall exit door, houses were visible approximately one block behind the facility. E40 could not remember if there has been any inservice on residents who are at risk for eloping but verified that the CNAs monitor and record every 15 minutes where R21 is located. E40 stated there are no other residents in the facility that attempt to elope.

On 04/21/10 at 11:00 a.m., E27 (Maintenance Personal) stated that he heard the D-Hall exit door alarm going off, asked if anyone was "ever going to check the alarm" and went down D-Hall to check to see if anyone had gone out. E27 opened the D-Hall exit door, stepped just outside the door (still holding onto the open door), but did not see anyone. E27 stated that he did not go out around the perimeter of the building to look. E27 stated that the only door with a "personal alarm bracelet" audible alarm was the front door. The other exit doors alarm when anyone opens them, regardless of whether they are wearing a personal alarm bracelet. E27 stated he reported to the nurse (E40) that he did not see anyone outside. E27 then went to the morning meeting at 9:00 a.m.. E27 stated that shortly after the meeting started, the police arrived and informed the facility staff that R21 was found on a neighbor's driveway, located on a street behind the facility. R21 had fallen and had been taken to the hospital. E27 stated that R21 was on 15 minute checks related to prior attempts to elope from the facility. E27 stated that there were a couple other residents that wore bracelet alarms only as a precaution, but that only R21 had ever made attempts to leave the facility.

On 04/21/10 at 11:25 a.m., E21/CNA (Certified

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F9999	Continued From page 169 Nurse Aide) stated that on 04/07/10, E21 had taken R21 to the bathroom and assisted R21 back to the dining room at 8:45 a.m. E21 stated that R21 had laid her head down on the table as if to go to sleep. E21 stated she was taking care of other residents when the D-Hall alarm went off. E27/Maintenance went to check the alarm and did not see anyone. E21 stated that around 9:00 a.m., the police informed the facility that R21 had fallen on a neighbor's driveway on a street located behind the facility. E21 stated the R21 was the only resident that makes attempts to leave the facility and staff do 15 minute checks every shift. During interview on 4/21/10 at 11:25 a.m., E21 stated she had documented at 8:45AM on 4/07/10 that R21 was in the main dining room. This conflicts with the police department report that the police received a call at 8:43 a.m. from the neighbor that R21 had fallen on the neighbor's driveway. E21 stated that the back door does not have a "personal alarm bracelet" alarm and that usually R21 attempts to go out of the front door. E21 stated she did not go and look for R21 since E27 had already checked to see if anyone exited the D-wing door. E21 stated that the police came to the facility around 9:00 a.m. and informed the facility that R21 was found about a block away at a neighbor's house. R21's physician orders dated 03/25/10, documents R21's diagnoses includes Schizophrenia Paranoid type, Mood disorder, Narcolepsy, Hypertension and Diabetes Mellitus. R21 receives Insulin per sliding scale twice a day, Glucophage for Diabetes daily, and antipsychotic medications daily. R21's care plan dated 02/09/10 documents R21 is delusional,	F9999		

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talks to self, requires the use safety devices/alarms (code alert), is to be monitored for attempts to exit the facility and staff redirection. There are no specific approaches on R21's care plan showing how to direct staff on how the facility is going to monitor R21, how to redirect R21 and what activities to offer R21. The care plan does not give specific behaviors R21 displays, and does not show R21's frequent attempts to elope. R21's care plan shows R21 is to receive therapeutic groups or 1:1 activities but does not give specific approaches for staff to follow.

On 04/20/10 at 12:20 p.m. R21 was at the dining room table. R21 got up from the table and went over to the nurse's medication cart and just stood and stared at the nurse and the medication cart. R21 went back to the dining room table to eat more lunch, but quickly got back up and went over to the sitting/television area. R21 began to dance with the music on the radio. E9 walked by and danced a few seconds with R21. E9 then had R21 sit in a chair by the radio and E9 left. As soon as E9 left, R21 got up and moved to the dining room and down C-hall. From 1:00 p.m. through 2:30 p.m., surveyors at the C-wing nurses station continuously observed R21 going up and down C-wing hall, stating she wanted to go out the C-wing exit door to go visit R21's sister. The 15 minute monitoring sheet for R21 on 04/20/10 at 1:00 p.m. had noted that R21 was in the bedroom at 1:15 p.m., 1:30 p.m., at 1:45 p.m., and at 2:00 p.m. that R21 was in the dining room. Monitoring locations on this sheet do not agree with surveyor's direct observations.

On 04/20/10 at 2:50 p.m., E22 (Licensed Practical Nurse), stated that R21 was the only

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F9999	Continued From page 171 resident that tries to elope from the facility. E22 stated that R21 had to be redirected often and wore a bracelet that alarmed if R21 tried to exit the front door. E2, Director of Nursing stated on that the only resident that attempts to elope from the facility was R21 and that R21 frequently attempts to exit the front door. E2 stated that the facility inservice for Elopement Risks consisted of placing a copy of the "Elopement Risk assessment Policy and Procedure" in the "new employee" staff packet for staff to read. E2 verified that the facility had not posted a list or pictures of residents that are at risk for eloping as per the facility Elopement policy. The facility's Elopement Risk Assessment Policy and Procedure documents, "residents "at risk" shall be subject to the facility elopement prevention protocol which entails the following practices and procedures: * Staff training emphasizing monitoring/observing the person's behavior and whereabouts. (The facility's 15 minute checks record shows only the time and whereabouts; not R21's behaviors). * Check during "rounds." * Posting a photograph at the front desk (The facility did not post a picture of R21 and did not post residents at risk for elopement including R21). *Attempting to engage the resident in suitable activities to prevent or diminish the opportunity to elope. * Small group interventions or One-to-one intervention; monitoring if necessary. without supervision.	F9999		

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F9999	Continued From page 172 "The resident should be reassessed if there is a need and all of the staff members assigned to watch/Monitor the front door are expected to refer to the list of residents who are deemed 'competent' and have Earned the privilege of leaving the facility unsupervised. The 'monitor' will only allow person on the "competent" list to leave the building without supervision." "The completed Elopement Risk Assessment should be placed in resident's medical record, the RAP summary Sheet for Behavior symptoms should reference this information, and an addendum may be added to the Behavioral symptom Rap indicating the results of this assessment." R21's RAP Summary for Behavior and for Moods was not completed. Behavior tracking record for February, March and April, 2010 shows R21 has no behaviors. R21's assessment dated 02/09/10 documents R21 has had no behaviors, but nursing notes show R21 frequently wanders and attempts to exit. An Elopement Risk Assessment dated 02/09/10, documents R21 has a history of wandering/eloping, has impaired judgment, does not respond favorably to staff re-direction when wandering into restricted, unauthorized areas, has the physical ability to leave the building, and becomes easily agitated, confused and/or disoriented/shows consistently poor judgment. The Elopement assessment notes to continue with (personal alarm bracelet) and to continue with 15 minute checks. Nursing notes indicate a history of R21's	F9999		

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attempts to elope. On 11/20/09, R21 went out of the front exit door and entered the front parking lot (R21 told the staff that she was "looking for her car.")

On 11/27/09, R21 went out of the C-hall exit door, alarming the exit door, and was redirected back into the facility. On 12/21/09, R21 attempted to exit the facility several times during the 2:00 p.m. to 10:00 p.m. shift. On 02/19/10 and on 04/18/10, R21 exited the front door, setting off the alarm, and was redirected back into the facility.

A second policy entitled Missing Residents was provided on 4/21/10. According to E1, Assistant Administrator and E2, Director of Nursing, during daily status meeting on 4/21/10, this policy has been in place for three years. The policy states as purpose: "to provide 24 hour supervision of each resident's safety."

Steps included in this policy direct staff as follows:

"3. Immediately following the alarm signal, staff shall check the alarm panel and respond to the door indicated.

4. The resident shall be assisted back into the building or a staff member will remain with the resident for supervision.

5. If a resident is found to be missing and unable to be located, a thorough search of the facility and the immediate grounds shall be initiated by facility staff, a head count shall be conducted if necessary and the administrator notified."

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F9999	Continued From page 174 According to nursing notes dated 04/09/10, R21 was found on the floor at the foot of her bed. R21 had no new marks but was very confused and did not respond to questions. New physician orders dated 04/09/10 specified that bilateral side rails were to be placed on R21's bed. At 10:00 p.m. on 04/09/10, nursing notes document that R21's side rails were still up, although R21 ambulated self to the nurses station. In 04/17/10 and 04/18/10 nursing notes, R21 was ambulatory, talking and laughing more, making comments of wanting to go see a relative and making several attempts to exit the front door. At 5:35 p.m. on 04/20/10, R21 was transferred to the psychiatric unit at the hospital for a psychological evaluation. E2, Director of Nursing stated on 04/20/10 at 2:50 p.m., that R21 was sent to the hospital for a psychological evaluation and will not be returning to the facility. (A) 300.615f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. This Regulation is not met as evidenced by:	F9999		

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(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
F9999	Continued From page 175 Based on record review and interview the facility failed to check the Illinois Department of Corrections sex registrant search page for 13 of 13 residents reviewed (R17,R14,R23,R30,R31,R32,R33,R34,R46,R19, R55,R56,R57). Findings include: Review of criminal history records for residents (R17, R14,R23,R30, R31, R32, R33, R34, R46, R19, R55, R56, R57) have no record of the facility checking the Illinois Department of Corrections sex registrant search page for these residents. E42(Social Services) stated on 04/19/2010 at 11:00a.m. that the Illinois Department of Corrections sex registrant search page has not been checked for these residents because she had not been successful in getting to the Illinois Department of Corrections sex registrant search page. (B) 300.625a) Section 300.625 Identified Offenders a) The facility shall review the results of the criminal history background checks immediately upon receipt of those checks. If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check unless the fingerprint-based check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident's health or lack of potential risk, such as the existence of a severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. (Section	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145987	A. BUILDING _____ B. WING _____	05/14/2010

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GALESBURG TERRACE	1145 FRANK STREET GALESBURG, IL 61401

(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
F9999	Continued From page 176 2-201.5(b) of the Act) The facility shall arrange for a fingerprint-based background check or request a waiver from the Department within 5 days after receiving inconclusive results of a name-based background check. The fingerprint-based background check shall be conducted within 25 days after receiving the inconclusive results of the name-based check This Regulation is not met as evidenced by: Based on record review and interview the facility failed to conduct a fingerprint based background check on 1of 3 residents (R23) who is listed as a sex offender on the Illinois Sex Offender Web Site. Findings include: R23 was admitted to the facility on 03/10/10. A name based background check was run on 03/17/2010 and shows no record. On 03/08/10 the Ilinois Sex Offender Information Web Site was checked and shows R23 is a sex offender. The Illinois Department of Corrections Web Site has not been checked. A fingerprint based background check has not been done on R23. E42(Social Services) stated on 04/19/10 at 11:10 a.m. that a fingerprint background check has not been done on R23. (B) 300.625f) Section 300.625 Identified Offenders f) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall immediately fax the resident's name and criminal history information to the Department. (Section 2-201.5(c) of the Act)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145987	A. BUILDING _____ B. WING _____	05/14/2010

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F9999	Continued From page 177 This Regulation is not met as evidenced by: Based on record review and interview the facility failed to submit criminal history background information and the residents names on 1of 3 resident sex offenders (R23) and 6 of 6 identified offenders (R46, R17,R34,R33,R32,R31) to the Department. Findings include: R23 was admitted on 03/10/10. His background check states no record. The Illinois Sex Offender Web Site shows R23 as a sex offender. The Illinois Department of Corrections Web Site was not checked for R23. R17 was admitted 05/22/09. His background check states felony convictions for manufacture and delivery of controlled substances and burglary. R33 was admitted on 05/14/09. His background check states felony convictions for burglary and aggravated kidnaping. R34 was admitted 09/29/09. His background check states felony convictions for domestic battery, battery, manufacture and delivery of cannabis, aggravated battery, and assult. R32 was admitted 03/11/10. His background check states felony convictions for aggravated assault, battery, and unlawful use of a weapon. R46 was admitted on 12/3/09. His background check states felony convictions for assault and aggravated assault. R31 was admitted on 12/11/09. His background check states felony conviction for armed robbery. E42(Social Services) stated on 04/19/09 at 10:30 a.m. that she did not know she had to submit criminal history information on identified offenders to the Department.	F9999		