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	145388	A. BUILDING _____ B. WING _____	C 03/08/2011

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RICHLAND CARE & REHAB	**410 EAST MACK OLNEY, IL 62450**

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F 520	Continued From page 9 since July 2010. This has the potential to affect 74 of 74 in house residents. Findings include: 1. Interview with E2, (Interim Director of Nursing, DON), at 10:45AM on 3-3-11 indicated she was hired 7-12-10 as the Minimum Data Set Coordinator. The DON resigned in December 2010 and E2 took that position on 12-17-10 until a new DON could be hired. E2 noted the facility has not had a Quality Assurance Meeting since 7-29-10 to identify quality deficiencies within the facility. 2. Interview with E1, (Administrator), at 11:20AM on 3-3-11 confirmed the facility had not participated in a Quality Assurance Meeting since 7-29-10 of which minutes reflect.	F 520		
F9999	FINAL OBSERVATIONS LICENSUE VIOLATIONS 300.610a) 300.1210a) 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	F9999		

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F9999	Continued From page 10 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations were not met as evidenced by:	F9999		

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F9999	Continued From page 11 Based on record reviews, observations, facility policy review, incident report reviews and interviews the facility staff failed to provide adequate supervision to prevent the elopement of one resident (R1) out of three sampled residents reviewed. The facility has identified 27 residents at high risk for elopement. R1's diagnoses include Dementia and Parkinson's Disease. R1 left the facility after dark without staff knowledge on 2-24-11. R1 required treatment for Hypothermia after being submerged chest deep in a ditch for 14 minutes. Findings include: 1. The medical record face sheet indicates R1 is a 69 year old male who was admitted to this facility on 3-11-10. The diagnoses includes Parkinson's Disease, Dementia, Hodgkin's Lymphoma, Psychotic Disorder, and Delusions. The most current Minimum Data Set (MDS) is dated 2-18-11 as a re entry assessment (from the hospital). This assessment notes R1's communication abilities as understands and is understood by others. R1's mode of locomotion was identified as a wheelchair. The Functional Status Section of the MDS (G0110) indicates at this time R1 was dependent for transfers, unable to ambulate and required staff performance for locomotion in the wheelchair. Limits in range of motion were noted with impairments on both sides of upper and lower extremities. (Section G0400) Interview with E3 (Registered Nurse), on 3-2-11 at 10:15AM indicated R1 had been very ill upon hospital return and was placed in a Hopsice bed. E3 commented she observed R1's health	F9999		

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improve on 2-23-11 and 2-24-11 for he was out of bed and propelling himself in his wheel chair in the halls of the facility.

The facility's initial incident report by E1 (Administrator) documents R1 was seen at 8:00PM in the facility on 2-24-11. The front door alarm sounded at 8:10PM. A caller called the facility at 8:20PM to report a resident had fallen out of a wheelchair near the facility. The resident (R1) was transported to the hospital by ambulance and treated for Hypothermia. This incident report indicates R1 stated he was going to Hardees.

The unsigned 7 day follow-up report dated 3-1-11 notes R1 is an alert and oriented resident and left the building at approximately 8:10PM to go to Hardees to get something to eat. He was discovered a half block away by a passerby at 8:20PM where he had fallen out of his wheelchair and down a slope onto the ground. He was seen in his pajamas at 8:00PM but had gone to his room and put on his coat and boots (loafer shoes of which R1 refers to as boots) and left. According to R1 in this report, R1 noted he was startled by traffic and stood out of his wheelchair and fell and his wheelchair toppled on him down a slope which prevented him from getting back up. The passerby called an ambulance and R1 was taken to the hospital for observation for Hypothermia. He was readmitted to this facility the following day.

R1 was interviewed by this surveyor at 11:25AM and 3:40PM on 3-2-11. R1 stated he recalled leaving the facility on the evening of 2-24-11. R1 noted he wheeled himself out the front door and

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was going to get something to eat at Hardees. R1 noted it was dark outside, raining and cold. R1 commented he tried to get out of the way of a car, could not see where he was going, and did not see the ditch where the wheel chair landed. He indicated the wheelchair turned over in the ditch and landed on his legs. He stated the water in the ditch was up to his shoulders. R1 said he was not scared but was cold. R1 stated he was going to Hardees because he wanted regular food. (Not pureed.) He did note when he pushed the front door open he heard the alarm sound.

The Hospital Emergency Department Report states the ambulance arrived at 2043. R1's temperature at the scene was 91 degrees Fahrenheit. R1 was transported by ambulance with warming en route. Treatment at the emergency room included continued warming, oxygen, warmed Normal Saline IV, Complete Blood Count, Complete Metabolic Panel, and Cardiac Profile. The report notes patient is presently too tremulous to obtain an Electrocardiogram. Body temperature was 97.6 degrees F by 2230. R1 was admitted to the hospital for observation and returned to the Nursing Home on 2-25-11 at 1500.

Upon return to the facility R1 was placed on the secured unit (D Hall) with 15 minute checks on his location. As of 3-7-11, the 15 minute checks are ongoing.

Observation of the the path R1 traveled indicates he left the facility's front entrance in his wheelchair and propelled through the parking lot then made a right (going West) onto Mack Avenue. His wheelchair went off of this Avenue

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into a ditch at the corner of the next road (Silver Street). The wheelchair turned over in a ditch approximately 86 yards from the front entrance of the facility. This Avenue is a well traveled street by local traffic. This ditch is approximately 3 feet deep. A security light was noted in the parking lot area and a street light was observed on the South side of the Avenue where R1 was found in the ditch.

According to an interview with Z3 (Emergency Medical Technician), at 11:20AM on 3-1-11, the ditch contained 2 to 3 feet of water. Z3 noted R1 was partially submerged up to his chest in water. The wheelchair was turned over and the resident's foot was caught in the wheelchair. The weather was rainy and cold. Z3 noted R1 was wearing a hospital gown, pajama bottoms, house slippers and a coat was beside him in the water.

An interview with E3 (Registered Nurse in charge of caring for R1 on the evening shift of 2-24-11) at 10:15AM on 3-2-11 indicated they heard the alarm go off at approximately 8:10PM and she went to the panel at the nurses station to see what area had set off the alarm. The panel indicated the front door and E3 stated she immediately went to this door and stepped outside approximately five feet but did not see any one. E3 noted it was dark and raining. E3 noted she yelled to E5 (Certified Nursing Assistant) who was in his car for break approximately 20 yards from the front door and asked him if he saw anyone leave. He noted he had just got back from getting coffee but had not seen anyone. E3 noted E5 got out of his car and said he would walk around the building. E3 came back into the facility and had a feeling that it

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could have been R1 because he was not in his room at 8:00PM when she parked her med cart by his room. (E3 noted she had seen R1 at approximately 7:50PM.) E3 noted she asked staff if they had seen R1 and no one could find him. While staff was searching in the facility for R1, a call came in to the facility asking if they were missing a resident. E3 stated an unidentified male said there was a man in the ditch between Mack and Silver Streets and did he belong to the facility. E3 stated she said probably because they were looking for a resident.

E5 stated in an interview at 3:00PM on 3-2-11 he had returned to the facility entering the East side of the parking lot from Mack Avenue when he saw E3 out the door of the front of the facility. E5 noted E3 asked him if he had seen anyone come out. E5 stated it was rainy with poor visibility and had not seen anyone. E5 noted he then checked both sides of the facility but did not check the road in front of the facility.

The weather channel web site notes at 8:25PM on 2-24-11 the facility city had light rain and was windy. The temperature was 39 degrees F with conditions feeling like 29 degrees. Winds were East North East at 20 miles per hour.

The facility failed to follow their undated Door Alarm Policy and Procedure. Staff did not announce a "Code Yellow Unknown Resident" when the exit alarm sounded. E10 (CNA) stated on 3-7-11 at 9:15AM she turned off the alarm without acknowledging a code status, i.e. Code Yellow Unknown Resident or Code Yellow All clear. E9 noted at 2:00PM on 3-3-11, she saw

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F9999	Continued From page 16 E10 shut the alarm off at the nurses station on 2-24-11 around 8:00PM. She noted she asked E10 what door alarmed and E10 did not respond. E9 stated she checked the two dining room exits and then went back into the break room to finish break time. Staff failed to follow their Elopement 1/2004 Policy and Procedure regarding searching the facility surrounding grounds. R1 eloped the facility without staff knowledge. (A).	F9999		