DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145388	A. BUILDING ______ B. WING ______	C **08/30/2011**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND CARE & REHAB	**410 EAST MACK** **OLNEY, IL 62450**

(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 Complaint Investigation #1152508, IL #54128. A partial extended survey was conducted.	F 000		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 record review, observations, and interviews the facility staff failed to provide adequate supervision to prevent the elopement of 1 of 4 residents (R3) reviewed for elopement in the sample of 4. The facility identified 8 residents (R1-R8)at risk for elopement. R3's diagnoses includes Vascular Dementia and Cerebral Vascular Disease with Right Hemiplegia. R3 left the facility on 08-14-11 between 6:30 - 6:48AM without staff knowledge. R3 was found by the local police in a ditch face down with her wheelchair on top of her. R3 required treatment at the hospital for a closed head injury. This elopement resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 08-22-11 when staff had been inserviced, residents had been reevaluated and alarms had been adjusted to assure staff would be alerted to a resident leaving at all exits, the facility remained out of compliance at a level that is not actual	F 323		9/23/11

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 323	Continued From page 1	F 323		

harm with the potential for more than minimal harm. The deficient practice remains uncorrected due to the facility needing time to assure that the new systems are functioning correctly.

Findings include:

1. R3's medical record face sheet indicates R3 is a 92 year old female admitted to this facility on 07-09-10. R3's diagnoses on the admission face sheet dated 07-09-10 include Vascular Dementia and Cerebral Vascular Accident with Right Hemiplegia.

The most current Annual Minimum Data Set Assessment (MDS) is dated 06-17-11 provided by E3 (MDS/Care Plan Coordinator). This assessment noted in Section C0700 and C0800 that R3 has a long and short term memory problem. Section C1000 codes R3's cognitive skills for decision making as severely impaired-never/rarely made decisions. R3's mode of transportation was identified as a wheelchair and is self-sufficient once in the chair according to Section G0110. The Functional Status Section of the MDS (G0110) indicates that R3 was dependent for transfers and unable to ambulate. R3 was coded with functional limits in range of motion noted with impairments on both sides of the upper extremities and one side of the lower extremity (Section G0400).

R3 was observed on 08-18-11 at 9AM on the secure unit (D Wing) with a self release waist belt and saddle type cushion in a wheelchair propelling herself with her feet. Anti-tip devices were observed on the back of R3's wheelchair. R3 was observed to have purple bruise under the

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F 323	Continued From page 2 right eye and yellow/green bruise across the bridge of the nose and across the forehead. E1 (Director of Nursing) stated on 08-18-11 at 8:30AM, that R3 is alert with confusion, oriented to person but not place or time. E1 stated R3 was on the secure unit (D Wing) from admission 07-09-10 until 03-28-11 when she returned from the hospital with a diagnoses of Pneumonia. At that time R3 was moved to C Wing. According to R3's nursing notes while R3 was on C Wing dated 07-16-11 at 4PM, R3 had some aggression toward another resident and had also attempted to exit the facility four times. Nursing note on 07-20-11 at 5:30PM, R3 again tried to kick another resident's wheelchair and to exit the facility multiple times. E1 stated R3's medical condition had improved and she was more mobile in the wheelchair but remained on C Wing. No reassessment was done to determine if R3 was at risk for elopement when her condition improved in July, confirmed by interview with E1 on 08-29-11 at 8:57AM. R3 was assessed on 08-09-11 in the clinical record on the facility's "Elopement Assessment" form to be at high risk. No changes to R3's care plan were noted related to the high risk assessment or the exit seeking behaviors noted in the nurses notes on 7/16/11 and 7/20/11, confirmed by interview with E1 on 08-29-11 at 3:30PM. The facility's initial incident report ,dated 8/14/11,to Illinois Department of Public Health by E1, documents R3 left the facility unattended between 6:30AM - 6:45AM on 08-14-11. Z2 (Police Officer) found R3 in a ditch across the road from the facility at 6:48AM. R3 was	F 323		

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F 323	Continued From page 3 transported by ambulance to the emergency room for evaluation and treatment. R3 returned to the facility the same day, with a diagnoses of Right hip Contusion and Closed Head Injury, according to the hospital "Emergency Department- Printed Discharge Instructions" dated 08-14-11. The facility incident report dated 08-14-11 at 6:48AM, states R3 had swelling of the nose and bruising of the bilateral bridge of nose. The hospital emergency department form dated 08-14-11 at 8:41AM documents R3 had tenderness in the right lateral hip area and dried blood in the right nares. The report also states an X-ray of the right hip was done at 08-14-11 and was negative for a fracture. R3 was discharged back to the nursing home in good condition with head injury instructions, according to the hospital emergency department form Disposition/Plan dated 8/14/11. No diagnostic tests were conducted at the hospital to determine the nature of R3's head injury, confirmed by interview with Z1 (Physician) on 08-18-11 at 1PM. According to the facility's "Incident Investigation" dated 08-16-11 completed by E1. On 08-14-11 between 6:30AM and 6:45AM, R3 exited the facility in her wheelchair. It was documented R3 was last seen by E14 (Certified Nursing Assistant) on 08-14-11 at 6:30AM. R3 crossed the road in front of the facility and fell in a ditch. When R3 fell the wheel chair fell with her and she remained in the wheel chair (attached by the self release seat belt) at the time of the fall. Z2 (police officer) was driving by the facility on 08-14-11 at 6:48AM and noted R3 in the ditch and stopped to assess the situation. At 6:49AM, Z2 called for an ambulance and motioned for E6 (Licensed Practical Nurse), E4 (Certified Nursing Assistant -	F 323		

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F 323	Continued From page 4 CNA) and E10 (CNA) to come to the scene. (These individuals were outside the facility in the smoking area to the West of the building and were seen by Z2.) R3's self release seat belt was released by E6 after assessing her. R3 was noted to have blood on her face and was taken by ambulance to the hospital for evaluation and treatment. R3 returned to the facility on 08-14-11 at 9:15AM with a diagnoses of Closed Head Injury and a Right Hip Contusion. Upon her return to the facility, R3 was assessed, neuro checks were continued and she was placed on 15 minute checks according to the written investigation dated 08-18-11 by E1. As of 08-18-11 the 15 minute checks are ongoing. R3's elopement risk status dated 08-14-11 and care plan dated 08-14-11 were updated after the incident. After consulting with R3's family, R3 was transferred to the secure Alzheimer's unit for additional safety. The facility's "Incident investigation" - timeline dated 08-16-11 was began immediately on 08-14-11 upon identifying R3 had eloped from the facility and a "Code Yellow" was initiated by the charge nurses to identify all residents were accounted for at 7AM on 08-14-11. The report indicated all staff on duty were interviewed regarding their knowledge of R3's whereabouts prior to the incident. E1 identified 2 staff members (E5 and E11-CNAs) that came in the West door at 6:30 or 6:33AM. Residents that smoke were taken out the West door to smoke by E6 (LPN) at approximately 6:45AM, according to interview with E6 on 08-18-11 at 12:55PM. E1 identified in the report that all door alarms all have approximately a 1	F 323		

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F 323	Continued From page 5 minute delay on them. If two door alarms sound at the same time and one is silenced that they are both silenced without the second alarm sounding. E2 stated R3 could have went out the East dining room exit door when the residents who smoke, went out the West dining room exit door. Staff may have silenced the West door and did not identify there were two alarms sounding at one time, according to E1 per interview on 08-18-11 at 1:45PM, but E1 was unable to determine if this occurred in her investigation or which door E3 exited.. R3 was interviewed at 9:02AM on 08-18-11. R3 did not recall leaving the facility or falling in a ditch across the road on 08-14-11. R3 was confused to her current location and date/time. R3 speech rambled and did not stay focused on a topic of discussion. When questioned what happened to cause the bruises on her face she stated "a guy knocked her out along the highway and brought me to the hospital the next day". R3 states she goes outside when she wants to. R3 stated she would put her jacket on before crossing the road and if cars were present she would stop and watch them go by. When R3 was asked about crossing a ditch she stated she would cross the ditch if the water was not too deep. R3 was unable to remove the lap seat belt on her wheelchair upon request. According to interview with Z1 on 08-18-11 at 1PM, R3 does not have safety awareness and is unaware of possible dangers. Observation of the path R3 may have traveled indicates she may have exited from the front door of the facility, East or West dining room exits. R3 traveled in her wheelchair propelling through	F 323		

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the parking lot then making a right (going West) on Mack Avenue. R3's wheelchair went off in a ditch on the north side of Mack Ave by a electrical pole next to an entrance to a business. The wheelchair turned over in a ditch approximately 200 feet from the front entrance of the nursing home facility. Mack Avenue is a busy street with heavy local traffic. The ditch is approximately 3 feet deep.

According to interview with Z2 on 08-18-11 at 11:45AM per phone, R3 was found in the ditch head down with the wheelchair on top of her. R3 was still fastened in the wheel chair with a seat belt. R3 was observed to have a scuff on her face and a bloody nose, according to Z2. Z2 called the ambulance for R3 at 6:49AM on 08-14-11. Z2 confirmed with E6 (LPN) at that time that the facility staff were not aware R3 had left the facility.

The weather for 08-14-11 at 7AM was 67 degrees sunny and clear, according to the facility's "Illinois Department of Public Health" reporting form dated 8/14/11. According to interview with E5 (CNA) on 08-18-11 at 11:30AM, R3 was dressed in a short sleeve knit shirt, sweat pants, shoes and socks.

Observation of East Dining Room door alarms with E1 on 08-18-11 at 3:35PM, noted the door alarm had a 60 second delay after the door code was entered on the key pad when entering or exiting before the alarm resets itself. Other exit doors (front door, West Dining Room exit, Wings A, C and D exit doors) in the facility have a 30 second delay before the door alarm resets, confirmed by interview with E9 (Maintenance

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F 323	Continued From page 7 Supervisor) on 08-29-11 at 2PM. E1 (Director of Nursing).was notified of the Immediate Jeopardy situation regarding R3 at 2:45 P.M.on 8/18/11. The Immediate jeopardy was determined to have begun on 08-14-11 between 6:30AM and 6:48AM when R3 eloped from the facility without staff knowledge. The Immediate Jeopardy was determined to have been removed on 08-14-11 at 9:15AM when R3 returned to the facility from the hospital, was reassessed and transferred to the secure unit. The facility implemented the following steps to remove the Immediate Jeopardy which reduced the severity to no actual harm with potential for more than minimal harm and the scope isolated. 1. Staff inservice education began by E1 on 08-14-11 after R3 eloped. Education included Door Alarms, Code Yellow, Motion Detectors and Elopement Policy and Procedures. All staff were inserviced by 10AM on 08-15-11, confirmed by interview with E1 on 08-29-11 at 3PM. 2. The facility staff evaluated R3 for elopement risk and she was placed on the secure unit with 15 minute checks on 08-14-11. R1's wandering assessment and care plan were updated on 8/14/11 to include high risk for elopement. 3. The door alarm system (10 exit doors) were assessed for proper functioning by E9 (Maintenance Director) on 08-14-11. There is a 60 second delay after the East Dining Room door alarm is deactivated before the alarm resets and if two alarms are tripped simultaneously there was no evidence 2 alarms were activated. Z4 (Contracted Alarm Inspector) was in the facility on	F 323		

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F 323	Continued From page 8 08-17-11 and reset the door alarms for less than one minute delay except for the East Dining Room exit door. Z4 coded individual exit doors so the facility staff could identify which doors had been exited from the facility when 2 alarms are tripped at the same time. The East Dining Room door was designated as a emergency exit and a 2nd shrill alarm was placed on this door on 8/22/11 (to be only turned off at the door). 4. On 8/15/11 staff reevaluated all in house residents. According to the facility's "Elopement Risk" form revised 8/2011, 2 residents(R2 R3) were identified as high risk for elopement , and 6 residents were identified as "at risk" for elopement (R1, R4, R5, R6, R7 and R8). Information to better identify at risk residents was added to the facility's elopement program book. 5. On 8/22/11, E1 developed an Interdisciplinary assessment tool to use for residents being moved off the secure Alzheimer's unit . A quality assurance tool has also been developed to monitor a residents move to the secure unit.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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	F9999		

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each resident's comprehensive resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures:

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations were not met as evidenced by:

Based on record review, observations, and interviews the facility staff failed to provide adequate supervision to prevent the elopement of 1 of 4 residents (R3) reviewed for elopement in the sample of 4. The facility identified 8 residents (R1-R8) at risk for elopement. R3's diagnoses includes Vascular Dementia and Cerebral Vascular Disease with Right Hemiplegia. R3 left the facility on 08-14-11 between 6:30 - 6:48AM without staff knowledge. R3 was found by the local police in a ditch face down with her wheelchair on top of her. R3 required treatment at the hospital for a closed head injury.

Findings include:

1. R3's medical record face sheet indicates R3 is a 92 year old female admitted to this facility on 07-09-10. R3's diagnoses on the admission face sheet dated 07-09-10 include Vascular Dementia and Cerebral Vascular Accident with Right Hemiplegia.

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Continued From page 10

The most current Annual Minimum Data Set Assessment (MDS), dated 06-17-11, was provided by E3 (MDS/Care Plan Coordinator). This assessment noted in Section C0700 and C0800 that R3 has a long and short term memory problem. Section C1000 codes R3's cognitive skills for decision making as severely impaired-never/rarely made decisions. R3's mode of transportation was identified as a wheelchair and is self-sufficient once in the chair according to Section G0110. The Functional Status Section of the MDS (G0110) indicates that R3 was dependent for transfers and unable to ambulate. R3 was coded with functional limits in range of motion noted with impairments on both sides of the upper extremities and one side of the lower extremity (Section G0400).

R3 was observed on 08-18-11 at 9:00AM on the secure unit (D Wing) with a self release waist belt and saddle type cushion in a wheelchair propelling herself with her feet. Anti-tip devices were observed on the back of R3's wheelchair. R3 was observed to have a purple bruise under the right eye and yellow/green bruise across the bridge of the nose and across the forehead. E1 (Director of Nursing) stated on 08-18-11 at 8:30AM, that R3 is alert with confusion, oriented to person but not place or time. E1 stated R3 was on the secure unit (D Wing) from admission 07-09-10 until 03-28-11 when she returned from the hospital with a diagnoses of Pneumonia. At that time R3 was moved to C Wing. According to R3's nursing notes dated 07-16-11 at 4:00PM, while R3 was on C Wing, R3 had some aggression toward another resident and had also attempted to exit the facility four times. Nursing

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F9999	Continued From page 11 note on 07-20-11 at 5:30PM, R3 again tried to kick another resident's wheelchair and to exit the facility multiple times. E1 stated R3's medical condition had improved and she was more mobile in the wheelchair but remained on C Wing. No reassessment was done to determine if R3 was at risk for elopement when her condition improved in July, confirmed by interview with E1 on 08-29-11 at 8:57AM. R3 was assessed on 08-09-11 in the clinical record on the facility's "Elopement Assessment" form to be at high risk. No changes to R3's care plan were noted related to the high risk assessment or the exit seeking behaviors noted in the nurses notes on 7/16/11 and 7/20/11, confirmed by interview with E1 on 08-29-11 at 3:30PM. The facility's initial incident report, dated 8/14/11, to Illinois Department of Public Health by E1, documents R3 left the facility unattended between 6:30AM - 6:45AM on 08-14-11. Z2 (Police Officer) found R3 in a ditch across the road from the facility at 6:48AM. According to the hospital "Emergency Department- Printed Discharge Instructions," dated 08-14-11, R3 was transported by ambulance to the emergency room for evaluation and treatment. R3 returned to the facility the same day with a diagnoses of Right hip Contusion and Closed Head Injury. The facility incident report dated 08-14-11 at 6:48AM, states R3 had swelling of the nose and bruising of the bilateral bridge of nose. The hospital emergency department form dated 08-14-11 at 8:41AM documents R3 had tenderness in the right lateral hip area and dried blood in the right nares. The report also states an X-ray of the right	F9999		

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hip was done at 08-14-11 and was negative for a fracture. R3 was discharged back to the nursing home in good condition with head injury instructions, according to the hospital emergency department form Disposition/Plan dated 8/14/11. No diagnostic tests were conducted at the hospital to determine the nature of R3's head injury, confirmed by interview with Z1 (Physician) on 08-18-11 at 1:00PM.

According to the facility's "Incident Investigation" dated 08-16-11 completed by E1, on 08-14-11 between 6:30AM and 6:45AM, R3 exited the facility in her wheelchair. It was documented R3 was last seen by E14 (Certified Nursing Assistant) on 08-14-11 at 6:30AM. R3 crossed the road in front of the facility and fell in a ditch. When R3 fell the wheelchair fell with her and she remained in the wheelchair (attached by the self release seat belt) at the time of the fall. Z2 (police officer) was driving by the facility on 08-14-11 at 6:48AM and noted R3 in the ditch and stopped to assess the situation. At 6:49AM, Z2 called for an ambulance and motioned for E6 (Licensed Practical Nurse), E4 (Certified Nursing Assistant - CNA) and E10 (CNA) to come to the scene. (These individuals were outside the facility in the smoking area to the West of the building and were seen by Z2.) R3's self release seat belt was released by E6 after assessing her. R3 was noted to have blood on her face and was taken by ambulance to the hospital for evaluation and treatment. R3 returned to the facility on 08-14-11 at 9:15AM with a diagnoses of Closed Head Injury and a Right Hip Contusion.

Upon her return to the facility, R3 was assessed, neuro checks were continued and she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145388	A. BUILDING ______ B. WING ______	C 08/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND CARE & REHAB	**410 EAST MACK OLNEY, IL 62450**

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F9999	Continued From page 13	F9999		

placed on 15 minute checks according to the written investigation dated 08-18-11 by E1. As of 08-18-11 the 15 minute checks are ongoing. R3's elopement risk status dated 08-14-11 and care plan dated 08-14-11 were updated after the incident. After consulting with R3's family, R3 was transferred to the secure Alzheimer's unit for additional safety.

The facility's "Incident investigation" - timeline dated 08-16-11 was begun immediately on 08-14-11 upon identifying R3 had eloped from the facility and a "Code Yellow" was initiated by the charge nurses to identify all residents were accounted for at 7:00AM on 08-14-11. The report indicated all staff on duty were interviewed regarding their knowledge of R3's whereabouts prior to the incident. E1 identified 2 staff members (E5 and E11-CNAs) that came in the West door at 6:30 or 6:33AM. Residents that smoke were taken out the West door to smoke by E6 (LPN) at approximately 6:45AM, according to interview with E6 on 08-18-11 at 12:55PM. E1 identified in the report that all door alarms all have approximately a 1 minute delay on them. If two door alarms sound at the same time and one is silenced, they are both silenced without the second alarm sounding. E2 stated R3 could have went out the East dining room exit door when the residents who smoke went out the West dining room exit door. Staff may have silenced the West door and did not identify there were two alarms sounding at one time, according to E1 per interview on 08-18-11 at 1:45PM, but E1 was unable to determine if this occurred in her investigation or which door E3 exited..

R3 was interviewed at 9:02AM on 08-18-11. R3

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F9999	Continued From page 14	F9999		

did not recall leaving the facility or falling in a ditch across the road on 08-14-11. R3 was confused to her current location and date/time. R3 speech rambled and did not stay focused on a topic of discussion. When questioned what happened to cause the bruises on her face she stated, "a guy knocked her out along the highway and brought me to the hospital the next day." R3 stated she goes outside when she wants to. R3 stated she would put her jacket on before crossing the road and if cars were present she would stop and watch them go by. When R3 was asked about crossing a ditch she stated she would cross the ditch if the water was not too deep. R3 was unable to remove the lap seat belt on her wheelchair upon request. According to interview with Z1 on 08-18-11 at 1:00PM, R3 does not have safety awareness and is unaware of possible dangers.

Observation of the path R3 may have traveled indicates she may have exited from the front door of the facility, East or West dining room exits. R3 traveled in her wheelchair propelling through the parking lot then making a right (going West) on Mack Avenue. R3's wheelchair went off in a ditch on the north side of Mack Ave by an electrical pole next to an entrance to a business. The wheelchair turned over in a ditch approximately 200 feet from the front entrance of the nursing home facility. Mack Avenue is a busy street with heavy local traffic. The ditch is approximately 3 feet deep.

According to interview with Z2 on 08-18-11 at 11:45AM per phone, R3 was found in the ditch head down with the wheelchair on top of her. R3 was still fastened in the wheelchair with a seat

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F9999	Continued From page 15 belt. R3 was observed to have a scuff on her face and a bloody nose, according to Z2. Z2 called the ambulance for R3 at 6:49AM on 08-14-11. Z2 confirmed with E6 (LPN) at that time that the facility staff were not aware R3 had left the facility. The weather for 08-14-11 at 7:00AM was 67 degrees sunny and clear, according to the facility's "Illinois Department of Public Health" reporting form dated 8/14/11. According to interview with E5 (CNA) on 08-18-11 at 11:30AM, R3 was dressed in a short sleeve knit shirt, sweat pants, shoes and socks. Observation of East Dining Room door alarms with E1 on 08-18-11 at 3:35PM, noted the door alarm had a 60 second delay after the door code was entered on the key pad when entering or exiting before the alarm resets itself. Other exit doors (front door, West Dining Room exit, Wings A, C and D exit doors) in the facility have a 30 second delay before the door alarm resets, confirmed by interview with E9 (Maintenance Supervisor) on 08-29-11 at 2:00PM. (A)	F9999		