STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145439	A. BUILDING _____ B. WING _____	C 08/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN URBANA NRSG & REHAB	**302 WEST BURWASH SAVOY, IL 61874**

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F 000	INITIAL COMMENTS Complaint #1463437/IL71260 - F279 and F323 cited Complaint #1463438/IL71262 - F279 and F323 cited Incident report of 6-28-14/IL71426 - No deficiencies	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a care plan for	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 279	Continued From page 1	F 279		

elopement risk for two of three residents (R1 and R3) reviewed at risk for elopement in a sample of three.

Findings include:

1. R1's Physician Order Sheet dated February 2014, shows R1 was admitted on 2-22-14. R1's Risk Assessment for Elopement dated 2-22-14 documents R1 is at risk for elopement from the facility and an electronic monitoring device was attached to R1's ankle as a precaution.

R1's 5-28-14 care plan does not contain any mention or interventions related to R1 being an elopement risk. An entry was added on 8-6-14 stating R1 is at risk for elopement related to Dementia, monitor that device is functional and in place, information is place in elopement book and to monitor resident frequently.

On 8-8-14 at 10:45 am, E12 (Care Plan Coordinator) stated R1 did not have a careplan for elopement risk until 8-6-14.

2. R3's Physician Order Sheet for June 2014 shows R3 was admitted 6-21-14. R3's Risk Assessment For Elopement dated 6-21-14 shows R3 is at risk for elopement.

On 8-7-14 at 1:30 pm, R3 was walking in the hallway with an electronic monitoring device attached to the ankle.

R3's care plan dated 7-1-14 does not contain any mention/interventions related to R3 being an elopement risk. An addition was made 8-6-14 stating R3 is an elopement risk and to monitor electronic monitoring device function, placement,

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F 279	Continued From page 2 monitor resident frequently, place resident information in the elopement book and to redirect resident if resident attempts to leave facility. On 8-8-14 at 10:45 am, E12 (Care Plan Coordinator) stated R1 did not have a careplan for elopement risk until 8-6-14.	F 279		
F 323 SS=D	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 observation, interview and record review, the facility failed to monitor one of three residents (R1) for elopement in a sample of three at risk for elopement. Findings include: Facility's investigation report dated 8-7-14 states the following: On 8-6-14 at 5:05 am, E6 (LPN-Licensed Practical Nurse) and E1 (Administrator) stated facility staff could not locate R1. R1's family was notified who eventually found R1 to be in another city staying at a family friend's house. R1 was returned to the facility on 8-6-14 at 9:15 am after local police took R1 to the police station until facility staff could return R1 to the facility.	F 323		

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F 323	Continued From page 3	F 323		

On 8-7-14 at 11:00 am, E1 stated the following: They have determined R1 was last seen at the facility on 8-5-14 after supper about 7:00 pm when R1 left the facility through the front door. R1 was not seen again until R1 was returned to the facility the morning of 8-6-14.

R1's POS (Physician's Order Sheet) for August 2014 documents R1 was admitted 2-22-14 and has diagnoses of Dementia, Urinary Tract Infection and Hypertension. An order dated 8-7-14 states to check functioning and placement of (electronic monitoring device) every shift.

R1's current MDS (Minimum Data Set) dated 5-28-14 shows R1 has a BIMS (Brief Interview for Mental Status) of 12 out of 15 having some difficulty with memory and needing supervision only for ambulation.

R1's Elopement Risk assessment completed on 2-22-14, 5-10-14 and 8-7-14, documents R1 to be at risk for elopement. An electronic monitoring device was attached to R1's ankle upon admission.

On 8-7-14 at 2:45 am, E6 (LPN) stated E6 was R1's nurse the evening of 8-5-14 from 6:00 pm to 6:00 am on 8-6-14. E6 stated E6 saw R1 about 6:30 pm on 8-6-14. E6 stated R1 usually request a sleeping pill around 8:00 pm, but since E6 and another nurse were splitting the hall where R1 resides, E6 assummed R1 had requested the sleeping pill from the other nurse. E6 stated E6 entered R1's room at about 1:20 am to check on another resident. E6 stated R1 was not in the room at that time but often is up at night so E6 did not think anything about it. At about 4:25 am, E6

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again entered R1's room and this time grew concerned when R1 was not there. E6 stated E6 checked with R1's CNA (Certified Nursing Assistant) E5, that shift who also had not seen R1. E6 stated a search was initiated, family notified and R1 found to be at a family friend's house 38 miles away. E6 stated R1 does wear an (electronic monitoring device) but E6 doesn't check the monitoring device and doesn't know who is responsible to check it.

On 8-7-14 at 1:45 pm, E4 (CNA) stated on 8-5-14, E4 was assigned to R1 and worked from 2:00 pm to 10:30 pm. E4 saw R1 at dinner time somewhere between 5:00 pm and 6:00 pm. E4 stated E4 did not see R1 after that stating R1 is self sufficienct and does not need E4's help. E4 stated E4 did not know R1 was an elopement risk or that R1 wore an (electronic monitoring device) around R1's ankle.

On 8-7-14 at 12:31 pm, E5 (CNA) stated on 8-5-14, E5 was assigned to R1 and worked from 10:00 pm to 6:30 am. E5 stated E4 (CNA) told E5 in report that R1 was "gone." E5 stated E5 took that to mean R1 was out of the facility on a pass with family. E5 stated E5 did not see R1 the rest of the shift.

On 8-7-14 at 1:30 pm, R1 was lying in bed with glasses and clean clothes on and an (electronic monitoring device) attached to R1's ankle. R1 stated on the evening of 8-5-14, the following happened: About 6:00 pm, R1 left the building out the front entrance. R1 triggered the (electronic monitoring device) alarm but the "girl at the front desk turned it off and let me go." R1 saw a bus and decided to go to another city and check on a friend, so R1 took the bus to another

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F 323	Continued From page 5 bus which took R1 to the city. R1 went to the friend's house and then to a family friend's house who let R1 spend the night. R1 awoke in the morning, cleaned up, and then was taken by the local police to the police station where facility staff picked R1 up and brought R1 back to the facility. R1 said I'm fine, I used to work in that city and I know my way around. On 8-7-14 at 11:20 am, E1 (Adminsitrator) stated it is facility policy that all residents be checked on at least every two hours. On 8-8-14 at 12:50 pm, E15 (Social Service Designee) stated the facility has an elopement book located at each nurse's station and at the front desk with pictures of all residents assessed as an elopement risk. E15 stated R1's picture was not in any of the books until after this incident.	F 323		