STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146064	A. BUILDING _____ B. WING _____	C 05/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE DECATUR	**2650 NORTH MONROE STREET DECATUR, IL 62526**

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F 000	INITIAL COMMENTS	F 000		
F 323 SS=E	Complaint Investigation #1562497/IL77097 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, record review and interview, the facility failed to supervise one of three residents (R1) reviewed for elopement (leaving the building unnoticed). The facility also failed to properly respond to an audible alarm signaling that R1 was leaving the building. R1 exited the facility without staff's knowledge, drove off in the facility vehicle, and became involved in a motor vehicle accident. This has the potential to impact 17 other residents identified at risk for leaving the facility unnoticed (R2-R18). Findings include: The Physician's Progress Notes dated 3/27/15 documents that R1 has a diagnosis of Psychosis. The Physician's Order Sheet (POS) dated May 2015 documents R1's diagnoses include Bipolar Disorder, Epilepsy, Depressive Disorder, Anxiety State, and Muscle Weakness. The POS lists R1's medications to include Risperidone (antipsychotic) 2 milligrams (mg) three times	F 323		

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

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daily, Haloperidol (antipsychotic) 5 mg one tablet twice daily, and Dilantin (antiseizure) 300 mg one capsule daily.

The Resident Assessment Instrument (RAI) dated 3/12/15 documents that R1 is cognitively impaired with disorganized thinking. Brief Interview for Mental Status (BIMS) dated 3/12/15 documents that R1's cognitive assessment score was five out of 15, which indicates severe cognitive impairment. The RAI documents that R1 walks with the assistance of one and that R1 balance is "not steady but able to stabilize without staff assistance."

R1's Elopement Risk Assessment dated 4/20/15 documents that R1 "responds poorly to staff re-direction when roaming into areas that are 'off limits' or unauthorized. Becomes agitated, confused and/or disoriented or displays consistently poor judgement (i.e., would not be able to safely care for him/herself outside of the facility)." The Elopement Risk Assessment also documents that R1 is "at risk to elope and should be placed on the Elopement Risk Protocol."

The Care Plan dated 3/18/15 documents that R1 is forgetful, disoriented and confused with short and long term memory impairment. The Care Plan also documents that R1 has exit seeking behaviors and attempts to leave the facility related to delusions believing his dad is in the parking lot. R1's Care Plan interventions include administer medications as ordered, notify the Medical Doctor as needed, offer reassurance, reorient/redirect as needed, know R1's whereabouts and 1:1 (one to one supervision). R1's Care Plan documents to ensure daily placement of R1's wireless, electronic monitoring

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system. The CNA (Certified Nursing Assistant) Care Plan Flow Sheet Report dated April 2015 documents that R1 is to be monitored for exit seeking behavior with the following approaches "praise positives, report agitation to nurse, offer diversion, redirect and know whereabouts." The CNA Care Plan Flow Sheet Report documents that R1 exhibited exit seeking behaviors on 4/1/15 at 6:51 pm, 4/3/15 at 6:42 pm, 4/4/15 at 5:56 pm, 4/12/15 at 9:41 am and 4/28/15 at 9:35 pm.

R1's Social Service Note dated 5/1/15 documents "Res (R1) was seen on camera sitting on floor by hall 6 door. Res (R1) stood up and pushed on the door, then sat back down by the door then stood up and pushed on the door...Res (R1) will be care planned to be monitored by doorways."

On 5/12/15 at 9:22 am R1 was walking into the dining room with a forward leaning posture and a shuffling gait. R1 had involuntary hand movements and slight drool from corner of his mouth. R1 exhibited a flat affect and did not make eye contact during interview. R1 stated that he "wanted to go for a ride" and he got into the facility's vehicle and the key was in the ignition. R1 stated that he was going to get a sandwich. During the query, R1 did not recall where he wanted to go to get the sandwich. R1 did not know the date, time, year, or season on 5/12/15. At the time of the interview R1 stated he believed he was in another community.

On 5/13/15 at 2:00 pm Z4 (R1's Psychiatrist) stated that R1 is not safe to function in the community without 24 hour supervision. On 5/13/15 at 12:22 pm E2, Director of Nurses, stated, "In my nursing judgement I don't think

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(R1) could function in the community alone. I don't believe he could take his own medication or cook his own meals."

On 5/12/15 at 10:25 am E1, Administrator, stated that the facility received a phone call at 5/6/15 at 5:45 pm from Z1, Community Member, that the facility van was seen driving in a residential area erratically. E1 said that Z1 stated that the driver was R1. E1 acknowledged that the facility was unaware that R1 had exited the facility until receiving the phone call from Z1. E1 stated that R1 and the facility vehicle were three miles from the facility. E1 stated that a resident head count was performed and R1 was missing. E1 and E4, Certified Nursing Assistant (CNA) traveled to the location of the vehicle and found R1 sitting in the driver's seat. E1 said that R1 stated that he "just went out for a ride." E1 stated that she and E4 returned R1 to the facility.

On 5/12/15 at 10:30 am E2, Director of Nursing stated that on 5/6/15 at approximately 5:45 pm "I was in the office with my door shut. I heard Code Purple, which means there is a resident unaccounted for. I grabbed my census sheet and started down each hall." E2 stated that E4 reported that she was unable to account for R1. E2 stated, "(E4) told me she last saw him (R1) at supper and he had asked for a second serving of supper and he ate it. I did not hear the alarm go off." E2 stated that staff need to respond immediately to an alarming door. "They need to be stepping outside the door that alarms to see if they see a resident exiting."

On 5/12/15 at 5:00 pm Z1, Community Member, stated that on 5/6/15 she witnessed R1 driving the facility vehicle, and rear-ending another

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vehicle, then leaving the scene of the accident. Z1 stated, "We were heading north on Monroe (Street) just got to Mound Road when the bus (facility vehicle) almost side swiped us on the driver's side. He (R1) was in the left turning lane and didn't turn. He (R1) went straight crossing Mound Road. Then, we were behind him and he was swerving right and left. When we got to the corner of Ash and MacArthur Road we noticed the bus jolted when he (R1) drove up on the curb and was headed into oncoming traffic. The white (vehicle) in front of him had been hit. After hitting the (vehicle) he (R1) started to drive off and I got him to follow me about another block. Then we got him to stop. I asked him to turn the key off. Then, I went to the passenger's side (of the facility vehicle) and took the key out of the ignition. It was one single key and it must have been in the bus. His (R1's) hands were shaking when he turned the ignition off. Other than saying his name he wasn't able to have conversation or answer questions." Z1 stated that she called the facility at 5:54 pm to report "bad employee driving". Z1 stated while she was still on the phone with the facility she saw the driver of the vehicle and said "I could tell it was a resident." Z1 stated that she was on the phone with E1. Z1 stated, "I told the facility (E1) that it was a resident who is driving the bus." Z1 stated that when she got R1 to pull over and stop "He (R1) told me his name." Z1 stated that E1 and E4 arrived to pick up R1. Z1 said that E4 stated "they heard the alarm go off (at the facility) and she (E4) wondered why it went off."

On 5/11/15 at 3:15 pm and 5:00 pm and 5/12/15 at 3:08 pm E4, CNA, stated that R1 "wanders down each hall and we have to constantly check on him." E4 stated that R1 wears an electronic

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monitoring device. E4 stated "Sometimes he (R1) goes to the exit door and will touch the glass and we redirect him to come back the other way." E4 stated that on 5/6/15, "We had a situation when he (R1) exited the building. I believe it was evening. I was assigned to him. He was in the dining room and asked for more food, which he got. I was assigned to the dining room. I believe he exited (the building) during the time I was in the dining room and transporting other residents out of the dining room." E4 stated that the door alarm went off and she was not sure which door sounded. E4 stated that there was a head count done on all residents and "I found out (R1) was missing. Several staff went to search for (R1) inside and out of the building. He has a (wireless, electronic monitoring system) so I am assuming he is at risk for wandering around." E4 stated, "After we found out where (R1) was missing (E1) asked me to go with her to pick up (R1). When we arrived at the scene (R1) was sitting in the driver's seat of the facility van." E4 stated that she (E4) and E1 returned R1 back to the facility. E4 stated that R1 was wearing the wireless, electronic monitoring system on his right ankle when she returned him (R1) to the facility. E4 stated that when R1 entered through the front door the "alarm went off."

On 5/11/15 at 1:15 pm E3, Regional Director of Operations stated that on 5/6/15 "a resident (R1) went for a joy ride." E3 stated that the Police were notified. E3 provided the Police Report/incident number. E3 stated that the driver of the facility vehicle on 5/6/15 was E6, Bus Driver (Facility Vehicle Driver). E3 stated that E6 left the ignition key in the vehicle. E3 stated that E6 "failed to secure the key to the vehicle."

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On 5/12/15 at 9:00 am E6, Bus Driver, stated "On 5/6/15 I went to (hospital) to pick up a resident (R19) to bring back to the facility. Then, I parked the bus and put the key in the cup holder tray and put some pennies on top of it. I then went into the facility."

The undated facility Motor Vehicle Safety Program policy documents, "When parking or leaving a vehicle, the following procedures must be followed: Shut off the engine, engage the transmission in park, set the parking brake, remove the ignition keys, and lock the vehicle."

The Illinois Traffic Crash Report obtained from the local Police Department dated 5/6/15 at 6:02 pm documents that R1 was the driver of Unit 1 (facility vehicle) and the driver of Unit 2 was Z2. The reports documents, "No injuries reported/evident. Units 1 and 2 were both heading N/B (northbound) on MacArthur Rd. approaching the intersection with Ash Ave (Avenue). Upon slowing to stop at the Stop Sign, Unit 1 (R1) hit the rear bumber (sic) of Unit 2 (Z2). Unit 1 Driver (R1) advised that he saw Unit 2 (Z2) slowing down, but was unable to come to a complete stop before rear ending Unit 2. The rear bumper of Unit 2 was observed to have the rear bumper dented on the left side and pushed in toward the body of the vehicle. Unit 1 Driver (R1) suffers from several mental and physical health conditions that impair his ability to reason and communicate. Unit 1 Driver (R1) does not have a valid drivers license and was not authorized to be driving the vehicle that he was in possession of. Due to his various mental and health conditions, Unit 1 Driver (R1) was not cited for this accident. This accident was witnessed by 2 individuals (Z1, Z3) who each advised that they

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both heard and observed Unit 1 (R1) rear-end Unit 2 (Z2) when Unit 2 slowed for the stop sign while N/B on N. MacArthur Rd at the intersection with W. Ash Ave." The Illinois Traffic Crash Report documents the Damage to any one person's vehicle vehicle/property was "over $1500."

On 5/13/15 at 10:45 am the facility's video camera monitoring system for door #2 documents that R1 exited the facility on 5/6/15 at 5:43:30 pm. The camera documents that E11, CNA, was first seen at the door at 5:47 pm. E10, CNA, arrived to check the door #2 at 5:48 pm. E8, CNA, and E9, CNA, arrived at door #2 at 5:57 pm and looked through the glass window of the door. E8, E9, E10, and E11 did not check the outside surroundings of door #2. Then, E12, Licensed Practical Nurse, reset the alarm at 5:48 pm.

On 5/12/15 at 2:00 pm E8, CNA, stated that on 5/6/15 she checked door #2 when the alarm was sounding. E8 stated that she looked out the door through the glass window but did not open the door to check the outside surroundings. On 5/12/15 at 3:05 pm E9 stated that the outside surroundings of door #2 were not checked when the alarm was sounding.

On 5/12/15 at 8:17 am and 11:05 am E5, Maintenance Director, stated that all exterior doors at the facility were alarmed and working when checked on 5/4/15 and that all exterior door alarms were checked weekly. E5 stated after the incident on 5/6/15 that E5 returned to the facility that evening and found all exterior door alarms were functioning as designed. E5 stated that there are three separate door alarm systems.

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One system is a door buzzer alarm system that buzzes when the door opens and remains sounding until the alarm is reset at the door. The second system is a magnetic 15 second delay, which sounds initially at the door for 15 seconds prior to opening. After 15 seconds the door releases and alarms throughout the facility. The third system is a wireless, electronic resident monitoring system that is worn by a resident and when a resident approaches the door the alarm will announce a warning throughout the facility and identifies the door number that is opened. The bracelet/activator is worn by residents that have been identified to be an elopement risk. The door alarms register at all four nurse's stations.

The facility's undated Elopement Prevention Devices and System policy documents "Elopement alert devices will be used as an interventional tool to prevent resident elopements." The undated Door Alarms policy documents, "A safe environment for the residents and staff will be provided to assure resident, staff and visitors safety. This will be accomplished by: 1. setting door alarms at all times and 2. Re-setting door alarms immediately after used." The Door Alarms procedure documents, "1. Set door alarms, 2. Monitor alarm panel to assure set, 3. Respond immediately when alarm sounds by checking alarm panel for location of alarm and proceed to door, 4. Investigate reason for an alarm, 5. Determine if all residents safe and accounted for, 6. Reset alarm."

The facility's Electronic Monitoring list dated May 2015 documents that R1-R18 wear a personal electronic monitoring device.