STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145495	A. BUILDING _____ B. WING _____	C 07/26/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDINA NURSING CENTER	**PO BOX 538 DURAND, IL 61024**

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F9999	Continued From page 7	F9999		

LICENSURE VIOLATIONS:
300.1210a)
The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial 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.

Section 300.3100d)2
General Building Requirements
All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.
These Requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to determine the location of 1 resident (R1) assessed as being at risk for elopement prior to silencing the activated door alarm. R1 left the facility unattended for a 15 minute period of time without staff knowledge on 7/5/05.

This is for 1 of 9 residents at risk for elopement (R1).

The findings include:

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F9999	Continued From page 8 R1's Physician's Order Sheet for July, 2005 documents that R1's diagnoses include Senile Dementia. R1's admission note dated 7/4/05 at 9:00 AM shows that on admission R1 had an electronic monitoring device applied to the Left Wrist. R1's Wandering Risk Assessment dated 7/4/05 shows a total score of 20. (Scores 15 or above require the application of an electronic monitoring device.) Review of R1's care plan dated 7/4/05 documents that R1 should be watched for exiting the facility. R1's Nursing Notes dated 7/5/05 for 7:30 PM documents that R1 was returned to the facility by an employee after being found walking on the side of the road. On 7-19-05 at 10:00 AM E15 (Registered Nurse) was interviewed. E15 indicated that on 7/5/05 she and another employee E16 (Certified Nursing Assistant) were off duty and driving northbound on the highway toward the facility about 6:00 PM. E15(RN) said they saw a woman walking along the left shoulder of the road. E15(RN) approached R1 and R1 stated " I guess I have to walk home." E15 stated that R1 was about 1 block from the facility near the bank. The mileage from the facility is 0.5 miles to the bank, the speed limit in front of the bank is 45 miles per hour. It was confirmed with E15 that R1 would have had to cross the road in order to be walking along the left shoulder.	F9999		

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F9999	Continued From page 9 E17 (Laundry worker) was interviewed on 7/19/ 05 at 11:10 AM. E17 said I was standing near the elevator on the second floor when a man came in. He said "there is an elderly lady outside and she might be from here." E19 (Social Services) was interviewed on 7/19/05 at 11:30 AM. E19 indicated that she was notified that R1 had gotten out of the facility and was returned by an employee. E19 stated that cameras installed in the facility showed that E22 (Certified Nursing Assistant) responded to the door alarm when R1 exited the facility. E22 looked out the door and then silenced the alarm and returned to work. E22 (CNA) was interviewed on 7/21/05 at 2:15 PM. E22 said that he responded to the door alarm on the PM of 7/5/05. E22 said he looked out the exit door and saw residents outside. E22 said R9 wears an electronic monitoring device and is allowed to sit outside. E22 said he saw R9 outside and thought she was the one who activated the door alarm. I turned off the alarm and went back to work. E22 said he saw another lady outside in the parking lot area who was carrying a Bible. I thought she was visiting , I had never seen her before. I found out later that it was R1. E8 (Student Nursing Assistant) was interviewed at 10: 45 AM on 7/20/05. E8 said I saw R1 around 4:30 PM sitting in the lounge area. I didn't know who she was. I didn't know she was a new resident and that she was at risk for elopement. I thought R1 was visiting another resident	F9999		

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F9999	Continued From page 10 E9 (CNA) was interviewed on 7/20/05 at 10:50 AM. E9 stated nobody knew R1 was new and had to be watched. E22 had never seen her before. E10 (CNA) was interviewed on 7/20/05 at 10:55 AM. E10 said I saw R1 in the lounge and I asked her name. I had no idea she was a potential to leave the building. Some residents wear electronic monitoring devices but they don't try to leave the facility. I don't think Z2 (Licensed Practical Nurse) knew it either. When R1 was returned to the facility I told Z2 (LPN) that one of her residents had just been brought back to the facility. E11 (CNA) was interviewed on 7/20/05 at 11:00 AM. E11 said E22 had no idea who R1 was. I knew we had a new resident, but I did not know R1 was a risk to leave the building, no one said anything to us. E12 (CNA) was interviewed on 7/20/05 at 12:35 PM. E12 said another nursing assistant (E22) was not aware of who R1 was and silenced the alarm. E13 (Registered Nurse) was interviewed on 7/20/05 at 11:10 AM. E13 stated that R1 was new, only in the facility a day or two. We were not very familiar with her. Z2(LPN) was at the other end of the building when the alarm sounded. Z2 (LPN) should have known about the alarm system. E14 (Certified Nursing Assistant) was interviewed on 7/20/05 at 1:35 PM. E14(CNA) said no one knew R1, none of us knew anything about her.	F9999		

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Z2 (LPN) was interviewed on 7/20/05 at 2:30 PM. Z2(LPN) said the only information she received in report was that R1 was a new admission. I was not told that R1 was an elopement risk and required special monitoring. The facility staff were not aware either. We did not know R1 was out of the facility until she was returned. If someone would have said R1 was a high risk I would have had my aides watch R1 closely. Z2 (LPN) indicated that she was not provided any information regarding the alarm system or electronic monitoring devices. Z2 (LPN) stated I was not told anything, I just didn't know.

Z2 (LPN) was interviewed on 7/21/05 at 3:15 PM. Z2 (LPN) stated that when R1 was returned to the building E19(Social Services) told me she was familiar with R1 and her family. E19 (SS) said that prior to R1's admission to the facility, R1 had she gotten out of the house and got lost in a corn field for about 2 and 1/2 hours.

Z1 was interviewed on 7/19/05 at 3:15 PM. Z1 indicated that R1 had lived at home prior to admission to the nursing home. Z1 said R1 had been leaving the house and they couldn't keep up with her, that is why she is there.

On 7/20/05 E2 (Director of Nursing) was interviewed at 1:25 PM. E2 said it was the responsibility of the nurse to tell staff about new residents at risk for elopement.

Z3 (Physician) was interviewed on 7/21//05 at 9: 35 AM. Z3 stated that R1 would be considered unsafe without constant supervision.

R1 was observed on 7/19/05 at 10:55 AM sitting

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F9999	Continued From page 12 in a chair near the second floor elevators. R1 was asked how she was doing today. R1 smiled and said "just fine." R1 was making circular motions with her hands over a news paper on her lap. R1 was asked if she lived here and stated "I like things like that." R1 was asked how long she lived in the facility and responded "a while now". R1 was asked how she liked living here and responded " I have six sons." On 7/19/05 at 12:50 PM exit door alarms were checked with E4 (Medical Records). Exit doors numbered 4, 6, 7, and 10 did not alarm when opened. E4 indicated that these doors have the alarms turned off during the day. E4 said these doors are used by lots of visitors. E4 was uncertain when the alarms were turned back on. AT 9:25 AM on 7/20/05 E1 (Administrator) was asked about the exit doors that did not alarm during the day. E1 indicated that the doors that were silenced during the day (4, 6, 7, 10,) are used by staff and visitors. The alarm system is automatic, the alarms on these doors are off at 5: 00 AM and back on at 9:00 PM. E1 confirmed that the facility did not have a policy and procedure for the silencing of these specific exit door alarms. On 7/21/05 at 12:15 PM E1 was asked how the facility supervises the exit doors that have silenced alarms during the day. E1 stated "We have had the same alarm system for 15 years."	F9999		