STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145443	A. BUILDING _____ B. WING _____	C 11/05/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS MANOR	**3615 16TH STREET ZION, IL 60099**

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F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 15 300.1210(a) 300.3100(d)(2) 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. 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 observations, record reviews and interviews, the facility failed to provide resident supervision to: 1) ensure that 2 (R6, R16) of 16 residents at risk for elopement not leave the facility unattended and without staff knowledge on 4/29/04, 9/7/04, 9 /30/04; 2) ensure that all door alarms are armed or directly monitored; 3) investigate and report R6's first elopement of 9 /7/04; 4) promptly investigate and report R6's elopement of 09/30/04;	F9999		

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F9999	Continued From page 16 5) notify the nurse supervisor and conduct a search after a door alarm sounded on 4/29/04; 6) thoroughly investigate R16's elopement of 4/29/04. The findings include: 1. R6 is an 89 year old resident who was admitted to the facility on 8/18/04. Physician's order sheet (POS) dated October 2004 document diagnoses of "Patient Wanders, Confused, Forgetful, Cerebral Vascular Disease with Hemiparesis, Dementia." Elopement Risk Assessment dated 8/18/04 documents a history of elopement at home and indicates that R6 wanders aimlessly, is confused and forgetful and ambulates with an unsteady gait. A fall risk assessment dated 8/26/04 assessed R6 as being at high risk for falls. R6's care plan dated 8/30/04 states the following goal, "Will not wander out of building, and will try and remember to ask for assistance when wanting to ambulate." The facility's Occurrence Report dated 9/30/04 reads, "Told that [R6] went out the South door of activity room. Alarm did not function...brought back into facility by visitor...Resident constantly wanders without regard to safety or where she is going." The time of R6's discovery is reported at 5:15 PM and the time that the resident was last observed is reported at 5:00 PM. The report states that a care plan intervention of "Constant supervision of resident" was initiated relevant to this occurrence. The facility's final investigation dated October 8, 2004 concluded: "The probability of [R6], exiting the building through the exit door on the	F9999		

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F9999	Continued From page 17	F9999		

northeast side of the building was highly likely after discovering that the alarm was off."

R6 was interviewed on 10/20/04 at 2:25 PM in her room. When questioned about crossing the street R6 stated that she would cross at the corner unless she was in a hurry, then she would cross in the middle of the street. R6 was not able to state whether or not a green light indicated that it was safe to cross the street and stated, "I would just take my chances." When questioned about leaving the building on 9/30/04 R6 stated, "I always go outside to go to the garage to get the car."

Z1, (visitor) was interviewed on 10/22/04 at 10:35 AM by telephone. Z1 provided the following information: On 9/30/04 while driving East on the driveway to exit onto 16th street R6 was observed to come out from between the buildings and walk toward the driveway leading to 16th Street. R6 didn't recognize Z1 even though they have known each other for over 50 years. R6 willingly got into Z1's car and stated that she was going home because her sister was making dinner. R6 then requested to be dropped off at the corner so she could go to the post office. Z1 drove R6 around to the front entrance and alerted staff that she had R6 in her car.

E16, (Assistant Director of Nursing) was interviewed on 11/3/04 by telephone and reported the following information: On 9/30/04 E 10 (housekeeper) told her that a resident was outside. E16 went out the front door where she was met by two visitors (Z1 and friend) who told her that they found R6 at the back of the building. R6 was sitting in the back of Z1's van. E16

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F9999	Continued From page 18	F9999		

brought R6 back into the building through the front door and notified E1 (Administrator) and E2 (Director of Nursing) about the incident. This occurred at 5:15 PM.

Z2, (R6's sister) was interviewed by telephone the afternoon of 10/20/04 and the following information was reported: R6 would be not be safe outside alone and would not be able to find her way home. R6 could not follow even simple directions to reach a destination. Z2 was informed of R6's 9/30/04 elopement when Z1 telephoned her on 10/2/04. Z2 then telephoned Z3 (R6's POAHC) and informed her of the incident. Z3 was not previously notified by the facility.

E4, (Restorative and Safety Aide) was interviewed on 10/20/04 at 3:00 PM in the conference room. E4 provided the following information: After being alerted to R6's elopement on 9/30/04 all the exit doors were checked to try to identify how R6 left the facility. The northeast activity room exit door was noted to not have a solid red light, indicating that it was unarmed. E4 pushed the exit door open and no alarm sounded. This door exits to a patio that is enclosed with a picket fence. The picket fence gate was noted to be open. E4 obtained the key for the door alarm and re-activated the alarm on the door. The red light came on indicating that the door was armed.

E3, (Director of Environmental Services) was interviewed on 10/20/04 in the morning. E3 provided the following information: To activate the alarm system on each of the exit doors you have to insert the key and rotate it one complete

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F9999	Continued From page 19	F9999		

turn. A solid red light appears to indicate the door alarm is activated. Most of the exit doors in the facility require a key to activate and de-activate the alarm system. Once an alarm is sounded it does not stop until it is manually turned off using the key. The nurses, maintenance personnel and Activity Director are the only staff who possess these keys. The transformer on the northeast activity room door was found to have gone out upon inspection on 9 /30/04 after the elopement incident. The door was operating on battery back-up. To conserve energy the red light flashes every 45 seconds instead of remaining solid. The changes in the pattern of the red light did not affect the alarm system on the door based on the tests conducted on the door. E3 stated, "It's possible that staff was a little confused and accidentally turned the alarm off instead of turning it on."

E2 (Director of Nursing) was interviewed on 10/ 20/04 in the morning and provided the following information: Based on her investigation nobody saw R6 leave the facility on 9/30/04 and no door alarms sounded. E2 surmises that a staff member inadvertently de-activated the alarm thinking that they were activating it. E2 was not able to identify which staff member may have done this because no staff member would admit to it. E2 conducted her investigation 10/4/04, 4 days after R6's elopement incident of 9/30/04.

E1 (Administrator) was interviewed at 3:30 PM 10 /20/04 in the conference room and provided the following information: On Saturday 10/2/04 E1 received a call at home from a nurse at the facility who informed her that R6's POAHC (Z3) wanted to speak with her. Z3 was upset because

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	145443	A. BUILDING _____ B. WING _____	C 11/05/2004

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ROLLING HILLS MANOR	3615 16TH STREET ZION, IL 60099

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F9999	Continued From page 20 she wasn't notified about R6's elopement incident of 9/30/04. E1 didn't know the full story at that time, but had only heard something about door alarms on Friday (10/1). E1 wasn't aware of the incident. E7 (floor nurse) was interviewed on 10/20/04 at 2 :15 PM in the conference room. E7 provided the following information: When family members come to visit residents they sometimes want to take them outside on the patio through the activity room exit door. The nurse de-activates the alarm to let the family and resident outside and then the door is left ajar so that they can come back inside. When he family member and resident come back inside the family tells the nurse and then the nurse re-activates the alarm. There is no constant monitoring of the door by staff when it is left ajar with the alarm de-activated. E11 (Nurse) was interviewed on 10/20/04 in the conference room and provided the following information: On 9/30/04 R6 was noted to be restless and was frequently getting up and down. R6 would get agitated if you tried to get her to sit down. E11 did not hear any door alarms sound on 9/30/04. Denies ever activating or de-activating alarm system on northeast activity room exit door. E12 (Certified Nursing Assistant) was interviewed on 10/20/04 in the conference room and provided the following information: Earlier in the afternoon on 9/30/04 R6 was noted to be restless and persistent with trying to go outside. E12 did not hear any door alarms sound on 9/30/04.	F9999		

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F9999	Continued From page 21	F9999		

E12 also stated that R6 was found outside several weeks prior to her elopement of 9/30/04. E12 stated that R6 was alone and unsupervised, walking on the driveway heading toward 16th street.

E1, E2, E3, E12, E13 (CNA) and E14 (CNA) were interviewed on 10/21/04 at 9:45 AM in E1's office and the following information was reported: R6 had previously eloped on 9/7/04 through the 400 hallway exit door. E13 was coming out of a resident's room at the beginning of the 400 hallway and saw R6 outside through the exit door at the end of the 400 wing. E13 yelled to E14, "I think one of your residents is out the back door." No alarm was sounding. When E14 went out the 400 exit door to retrieve R6 he noticed that the door was ajar. E12 and E13 also went out this door to retrieve R6. E12, E13 and E14 all reported that no alarm sounded when they went out the door. The 400 wing floor nurse (E18) also came down the hall to retrieve R6. E3 (Director of Environmental Services) tested the door alarm on 9/7/04, after this incident occurred, and found it to be in working order. E13 stated that the door should have alarmed. E13 said that the door had an older circuit board so she changed it out. E1 and E2 were not aware of R6 's elopement of 9/7/04 because it was not reported to them by staff. No incident report was initiated and no investigation was conducted. There is no documentation about this incident in the medical record. R6's POAHC (Z3) was not notified.

2. R16 is an 82 year old resident who was admitted to the facility on 2/27/04 with several diagnoses including Arteriosclerotic Dementia

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ROLLING HILLS MANOR	3615 16TH STREET ZION, IL 60099

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F9999	Continued From page 22 with Delirium per physician's order sheet dated October 2004. Admission Elopement Risk Assessment dated February 2004 documents, "One time - tried to leave during the night...worsening mental condition...gait has become unsteady - history of fall at home...expresses to go home." R16 is at high risk for falls per Fall Risk Assessment dated 4/16/04. Resident Accident/Incident Report dated 4/29/04 reads, "Laundry aide (E17) told me (E4) she saw a lady walking from (the facility) Campus towards the parking lot asking her if she could help." The report states that the resident (R16) was trying to walk down Route 173. Route 173 has a speed limit of 50 MPH and is located adjacent to the facility. The report did not include an investigation of how R16 exited the building. E17 (Laundry Aide) was interviewed, on 11/3/04 at 11:40 AM by telephone, about the incident of 4 /29/04 and provided the following information: E 17 was getting out of her car in the front parking lot and saw a woman (R16) on the sidewalk walking away from the building. E17 stated, "I didn't know where she came from...I don't know how she got out" R16 walked toward E17 and told her that she was getting some fresh air. R16 then started to walk toward Route 173. E17 realized that R16 might need help and ran over to alert E4 who was sitting outside by the bench. E 17 ran after R16 and caught her a few feet from Route 173. E4 (Restorative/Safety Aide) was interviewed on 11/3/04 at 10:50 AM and provided the following information: E4 stated that R16 exited the	F9999		

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F9999	Continued From page 23	F9999		

nursing home through the 200 hallway door which leads to a hallway with another exit which leads to outside. E4 stated that the 200 hallway door alarm sounded and that a CNA checked the hallway and didn't see anyone so he turned the alarm off. E4 stated, "technically, they're supposed to do a search." No search was initiated. E4 could not recall the name of the CNA who turned the alarm off.

R16 was observed on 10/21/04 at 2:55 PM. R16 's code alert apparatus was in place. R16 was pleasant but confused and could not be interviewed.

3. On 10/20/04 all exterior exit doors were checked with E3. All exit doors, except for the front door and the 200 hallway door (which connects with the assisted living building), are equipped with an alarm system which requires a key to activate and de-activate. In order to activate the door alarm a key must be inserted and turned 1 full revolution counter clock wise. A red light then appears to indicate that the door is armed. When the armed door is opened an alarm sounds until the key is inserted and turned.

The front entrance door is armed with a code alert system that alarms when a resident wearing a code alert apparatus enters into the doorway. The 200 hallway door has a keypad alarm system that does not require a key to de-activate. If the door is opened, without first entering the code on the keypad, an alarm will sound until the code is entered. A code alert system was added to this door after R16 eloped on 4/29/04.

The facility's Resident Wandering/Elopement

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F9999	Continued From page 24 Policies and Procedures states, "At no time shall a door alarm be turned off, without the continual supervision of the exit. The person responsible for turning off the door alarm shall be responsible for re-setting the alarm and ensuring that it is in working condition." The policy further states, " When a door alarm sounds, staff shall immediately respond to determine the cause of the alarm. The staff person responding to the alarm will check the outside of the building to determine if a resident has exited the building. If upon investigation no reason can be found for the sounding of that alarm...the nursing supervisor shall initiate an accounting of all residents at risk for elopement."	F9999		