STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. BUILDING _____ B. WING _____	C 05/31/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEY CARE CENTER	**5 DOCTORS PARK MOUNT VERNON, IL 62864**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F9999	FINAL OBSERVATIONS 300.1210a) 300.1210b)4) 300.1210b)6) Adequate and properly supervised nursing care and personal care shall be provided to each	F9999		

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resident to meet the total nursing and personal care needs of the resident.

Personal care shall be provided on a 24 hour, seven day a week basis.

All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance devices to prevent accidents.

The regulations are not met, as evidenced by the following:

Based on interviews, observation, and record review the facility failed to: a)provide adequate supervision to prevent a resident from eloping, for 1 of 31 residents residents assessed to be at high risk for elopement. The resident was R1. R1 has a diagnosis of Dementia per review of her admission sheet and her current physician's order sheet dated 5/05. R1 has a history of attempting to leave the building and exited the facility on May 15, 2005 without staff knowledge.

The findings include:

1. R1 is a 90 year old resident with diagnoses which include Dementia and Diabetes Mellitus per review of her admission sheet and current physician's order sheet dated 5/05. R1 was placed on Hospice on 5/9/05 for Alzheimer's Dementia and Adult Failure to Thrive. R1 was admitted to the facility on 6/12/04. R1's nurses notes dated 5/7/05 "resident upset states "Dad is sick" hitting laundry room door several times, wanting to leave." R1's nurses notes dated 5/10/05, state " up and about ambulating non-stop,

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very hard to redirect." R1's 5/11/05 nurses notes, state "resident up ambulating in facility going from door to door, setting off alarms." R1's nurses notes dated 5/15/05, R1 was hitting door alarms east back door, mop room, back hall, center court from 2PM till time of elopement. At approximately 3PM center court was called by charge nurse to check and clear. Staff called center court checked and cleared. At approximately 3:10PM the facility was notified resident was at Hospital Emergency Room sitting in a chair. Staff members and charge nurse went to Hospital Emergency Room to get resident.

Interview with Z4 on 5/25/05 at 4:00PM, "I heard that we had a patient in the doorway of the Hospital Emergency Room waiting room." Z4 said that she observed a female resident wandering around and that she appeared lost. Interview with E2 (director of nurses/registered nurse) on 5/23/05 at 2:40PM, no staff was aware of resident missing until they were notified by hospital staff. Interview with E3(licensed practical nurse) on 5/23/05 at 1:50PM, confirmed that she was charge nurse on 5/15/05 the date of R1's elopement. E3 said that she had observed R1 ambulating in the hallway 10 to 15 minutes prior to receiving notice that a resident was found at the Hospital Emergency Room waiting room. According to E3, R1 was seen at approximately 2 :55PM hitting door alarms. E3 said the front door alarm did not sound with the electronic monitoring device when R1 was returned to the facility. This is the door with the electronic monitoring alert. According to E3, all residents with electronic monitoring devices were checked via the electronic monitoring box and were working properly. All doors were checked and

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were working properly. According to E3, R1 was oriented to name but not to place. E3 said that they were not aware that a resident was missing until contacted by the hospital.

Interview with E4(certified nurses aide) on 5/23/05 at 2:25PM, "I was working the day R1 left the facility, no one was aware that she was gone until we were notified. R1 frequently goes to the doors and sets off the alarms. She walks fast at times and it is hard to keep up with her when she is in a fast mode." E3 and E4 said that they went to the hospital immediately when they were contacted and returned R1 to the facility. E3 said that when R1 starts setting off door alarms that she goes and tries all the doors and that is what she was doing the day of her elopement. E6(certified nurses aide) was interviewed on 5/25/05 at 3PM. E6 states R1 was looking for her husband the day of the elopement and that R1 calls her husband "Dad". According to E6, R1 was going from door to door at a very fast pace and that she spit on us, hit, kicked, and swung at us. According to E6, R1 was concerned about getting out of the building and that she was trying all the doors. E6 said that R1 was steady on her feet but was leaning to the right before and after the elopement. R1 was not oriented to time and place but knew her name. Written staff statements were provided with the facility incident investigation. E7's(certified nurses aide) written statement said that E7 observed R1 in the dining room on 5/15/05 at 3:03PM as she was leaving for the day.

Interview with Z2 on 5/24/05 at 1:40PM per phone, Z2 said that R1 is in the facility with Alzheimer's Dementia on a locked unit and that

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F9999	Continued From page 12 she needs to be on a locked unit. Z2 said that R 1 does not know what she is doing and that it is unsafe for her to be outside by herself. According to the local newspaper, the weather was partly cloudy on 5/15/05 with a slight chance of rain with the high 63 and the low 42. According to the facility incident report, R1 was appropriately dressed for the weather of 67 degrees. R1 had socks on with textured socks over the top.	F9999		