DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
				A. BUILDING		С		
		145	395	B. WIN	IG			9/2005
NAME OF PROVIDER OR SUPPLIER REHAB & CARE CTR - JACKSON CO					14	REET ADDRESS, CITY, STATE, ZIP CODE 441 NORTH 14TH STREET IURPHYSBORO, IL 62966		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEI MUST BE PRECEEDE SC IDENTIFYING INFO	D BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLETION DATE
F9999 FIN	AL OBSERVAT	TIONS		F99	999			
300 The ser pra wel eac pla	vices to attain or cticable physica I-being of the re th resident's con	ovide the necess r maintain the hig I, mental, and ps sident, in accord nprehensive asse late and properly	hest ychosocial ance with essment and	1 Fa	cility (D: IL6004816 If col	ntinuation she	et Page 5 of 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

F9999 Continued From page 5 nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 300.1210b)6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 300.3100d)2) 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 parttime use. If there is constant 24-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER REHAB & CARE CTR - JACKSON CO (X4) ID PREFIX TAG (X4) ID PREFIX TAG CONTINUED FROM LECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F9999 Continued From page 5 nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 300.1210b)6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 300.3100d)2) 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 partitime use. If there is constant 24-			145395	B. WIN	1G _			
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hour-a-day supervision of the door, a signal is not required. Based on interviews, observation, and record review the facility failed to provide adequate supervision to prevent a resident from eloping. For 1 of 30 residents assessed to be at high risk for elopement, the resident was R-1. R-1, who has a diagnosis of Alzheimer Dementia and a history of attempting to leave the building, exited the facility on 05-10-05 without staff knowledge. Findings Include: 1. R-1 is a 69 year old male, his medical diagnosis is listed as Alzheimer's dementia on the physicians order sheet dated 05-07-05. R-1 was admitted to the facility on 05-07-2005 from his home. Per the admission nursing note made at 11:15AM, R-1 had a history of agitation and	F9999	nursing care and per to each resident to personal care need 300.1210b)6) All necessary precassure that the resident resi	ersonal care shall be provided meet the total nursing and s of the resident. autions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see eccives adequate supervision prevent accidents. all be equipped with a signal aff if a resident leaves the or door that is supervised ds may have a disconnect use. If there is constant 24-sion of the door, a signal is not as sessed to be at high risk resident was R-1. R-1, who alzheimer Dementia and a g to leave the building, exited as Alzheimer's dementia on a sheet dated 05-07-05. R-1 a facility on 05-07-2005 from admission nursing note made	F99	999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145395	B. WIN	IG _) 2 /2005
NAME OF PROVIDER OR SUPPLIER REHAB & CARE CTR - JACKSON CO			•	14	REET ADDRESS, CITY, STATE, ZIP CODE 441 NORTH 14TH STREET MURPHYSBORO, IL 62966	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CF TAG REFERENCED TO THE APPROPRIATE DEFICI		BE CROSS-	(X5) COMPLETION DATE
F9999	state that R-1 is "wibuilding going door building". On 05-08 8AM., say that R-1 throughout the building". nurses notes say RA t 8:AM., on 05-09 attempted to exit buappear to comprehe On 05-10-05 at 5:5 staff was alerted by down the road in froand E-4 (CNA) we 05-16-05 this surve where R-1 had be 3 exited the buildin thought R-1 had dowalked approximate the roadway that Rapproximately 2 modriveway to the spoplace she found R-the street was a slig The street in questing The street is is pavalong the edges of Per interview with E3:55PM., R-1 had device applied on facility and all resid device are to be chinutes. Per E-2, vinto the facility at approximate part of the facili	I., on 05-07-05 nurses notes andering aimlessly about the to door attempted to exit the 3-2005 nursing notes made at is "wandering aimlessly ding with multiple attempts to At 12:00AM., on 05-09-2005 -1 is "wandering aimlessly". It is "wandering aim	F99	999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145395	B. WIN	IG		C 05/19/2005	
NAME OF PROVIDER OR SUPPLIER REHAB & CARE CTR - JACKSON CO			•	14	EET ADDRESS, CITY, STATE, ZIP CODE 141 NORTH 14TH STREET IURPHYSBORO, IL 62966		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F9999	all be in working or worn by R-1) did no solarium exit door of The E wing exit is the facility. Per E-having heard or resexit at the time R-1 Interview was done phone at 8:05AM., facility 05-10-05 at she started down the male standing in the street in front of the as a resident from the she was cautious a because she had on and combative with what R-1's respons 1 was walking down the facility alking down the facility walking down the facility walking down the facility alking down the facility alking down the facility alking down the facility. Z-1 stated that R-1 without supervision Alzheimer Dementi interview done 05-1	der. The electronic device (ot sound on the A wing or on the E wing exit door. he one staff believe R-1 exited -2 all staff interviewed denied set an alarm on the E-wing	F99	999			