STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145753	A. BUILDING _____ B. WING _____	05/24/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE CARE CENTER	1701 NORTH BOWMAN DANVILLE, IL 61832

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F9999	FINAL OBSERVATIONS Section 300.1210 a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological 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. b) General nursing care shall include at a	F9999		

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minimum the following and shall be practiced on a 24-hour, seven day a week basis:
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.

Section 300.3100
d2) 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.

Based on observation, record review, and interview, the facility failed to implement interventions to monitor the whereabouts of one out of 16 residents identified with exit seeking behaviors(R19); and failed to ensure that 2 of 2 exit doors were supervised when the door alarms had been deactivated. R19 left the facility without staff knowledge or supervision.

Findings include:

According to the current Physician's Order Sheet (POS), R19 was admitted to the facility on 4-18-05. R19 is 43 years old and has diagnoses that include: Traumatic Brain Injury (TBI) with explosive outbursts in behaviors, Depressive Disorder, Anxiety Disorder, Manic Disorder, and Behavior Disorder.

The 4-25-05 Resident Assessment Instrument (

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RAI) for R19 documents the following: R19 has short term memory deficit, is moderately impaired for daily decision making and requires supervision and cues. R19 is easily distracted (difficulty paying attention; gets sidetracked) and his mental function varies over the course of the day. R19 ambulates independently.

The facility's 5-16-05 incident report of the elopement(leaving the facility without staff knowledge) of R19 includes the following: R19 was last seen by E12, Licensed Practical Nurse(LPN) at approximately 3:30 P.M. on 5-16-05. At 4:00 P.M. E14, Certified Nursing Assistant(CNA) was unable to locate R19 when checking on the residents assigned to her. E14 immediately notified E12. The facility staff searched inside and out. R19 was not found. At 4:17 P.M., a call was made to 911, Management staff were notified, and staff began searching the area. R19 was found by the local police at 5:07 P.M., and returned by the police at 5:13 P.M. R19 was dressed in a T-shirt and sweat pants. The temperature was 56 degrees Fahrenheit at about 5:00 P.M. When R19 was returned an assessment was conducted; R19 had dirt and bits of tar on his feet and 2 pinpoint abrasions on the ball of his left foot. R19 was not wearing shoes, just socks. A personal electronic monitoring device was placed on R19, and fifteen minute locator checks were initiated. The report documented that R19 occasionally wanders within the facility, has difficulty remembering where his room is, but had never made any previous attempts to exit the facility.

According to the facility's incident investigation notes, Z1 (Police Officer) found R19 by a viaduct

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and railroad tracks. The location where R19 was found was observed on 5-17-05 at about 7:40 A. M. The location was measured to be 1.2 miles north and west of the facility. R19 would have walked north on the edge of a busy two lane main road. The section of east west road that R 19 was found on narrows to provide only one lane which both east and west bound traffic drives on, requiring traffic to yield to oncoming traffic thru the viaduct.

The activity care plan dated 4-21-05 listed R19 to have a "High-risk elopement factor." The care plan does not list approaches to monitor R19's whereabouts, do visual observations, or use an electronic monitor device. E17, Activities Aid was identified as the author of the activity care.

On 5-17-05 at 2:20 P.M., E17 was asked how she determined R19 had a "High-risk elopement factor". E17 said it came from transfer information received from the facility where R19 had previously resided.

At 2:30 P.M. on 5-17-05, E1, Administrator and E 4, Social Service Designee, were interviewed, and R19's complete medical record was requested. The transfer information referenced to by E17 was not in the medical chart. E4 and E 1 provided copies of the transfer information for review. A large part of the medical information had a fax date of 3-29-05. E4 and E1 stated they had the transfer information at least two weeks before R19 was admitted on 4-18-05.

The following documentation was included in the transfer information. The "Outcome Goal Plan Update" dated 3-24-05 under "participation

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restrictions" states, "Decreased cognitive status: confused, agitated, requires 24 hour supervision, decreased insight to injury and resultant deficits, and decreased safety awareness." Further stated, R19's "elopement attempts have decreased." The "Discharge Recommendations" lists the discharge date of 4-18-05. Under the section "Physical recommendations" the following was in bold type "This is important (R19) is at high risk to elope at any time." It continues to read "this is especially true when he appears agitated and the weather is warmer, however he has attempted to elope under other conditions as well. Please watch him carefully when in any unsecured environment, as he can appear to be a visitor rather than a resident because he does not have any physical impairments." A "Report of Physician" to the Circuit Court was dated 8-18-03 and completed by Z2 (R19's attending physician). The report stated "He is not able to maintain a level of orientation and self awareness adequate to function safely outside a highly structured and supervised environment."

The facility's "Elopement Risk Assessment" policy and procedure was reviewed. The policy and procedure was issued on 8-29-99. It states "A resident's elopement risk will be assessed using the Elopement Risk Assessment (Form#: RC4.16.1) upon admission, quarterly and as needed." The procedure is, the assessment is to be done with the RAI and "Residents who have been identified as low, moderate or high risk will be care planned." R19's Elopement Risk Assessment of 4-18-05, that was completed by E 3 (Assistant Director of Nurses/ Acting Director of Nurses), was reviewed. R19 was identified to occasionally pace, walk the halls and be restless.

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F9999	Continued From page 25 R19 was assessed as no potential for elopement with an initial score of 2 and was written over with a score of 5, that assesses R19 at a low potential for elopement. R19 resides in the facility's South Building. The facility's South Building is equipped with door alarms at all doors to alert staff if someone exits the facility. There are two alarm systems in place . At the time of the incident, all but two doors were alarmed and functioning 24 hours a day. E 15, Environmental Supervisor and E7, Maintenance Director were interviewed at 3:45 P. M. on 5-18-05. They stated the front and the smoke (the back patio) doors are alarmed from 6: 00 P.M. to 6:00 A.M. The alarms are disconnected between 6:00 A.M. and 6:00 P.M. They further stated that a separate alarm system is on these two doors for the resident electronic monitoring devices and it is not disconnected at any time. They stated the alarm systems were tested following the incident on 5-14-05 and have been functioning as designed without any problems. R19 was not wearing a electronic monitoring device at the time of the incident. Observations were made during the survey and there was not always someone at the nurses' station to have visual supervision of the smoke door or in the receptionist area to have visual supervision of the front door. E20, receptionist assigned to work in the front office on Saturday 5-14-05 was interviewed on 5-17-05 at 4:00 P.M. E20 stated that she did not always have visual supervision of the front door. E20 stated she had to answer the phone and she had a lot of copying to do. E20's back would be	F9999		

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F9999	Continued From page 26 facing the window in the office in which she would use to look at the front doors while she was making copies. The Nurses Notes for 5-14-05, date of the incident, recorded that E19, facility Van Driver, had seen R19 at an intersection south of the facility. E19 was interviewed on 5-18-05 at 3:30 P.M. E19 stated he was just inside the front door of the facility, waiting for a resident. He said he saw R19 by the south facility sign and the end of the parking lot between 3:15 P.M. and 3:30 P.M. on 5-14-05. He stated he did not know that R19 could not be out of the facility. He did not tell anyone he saw R19 until he was made aware of the elopement later. R19 was interviewed on 5-18-05 at 1:00 P.M. R 19 was in the dining room for the wing. He was asked to talk in his room. He walked passed his room and had to be redirected to his room. He did not know which room was his room. He did not know date, time, season of the year, the location of the facility or the name of the facility. He was asked where he was going on 5-14-05. He said "to my dad's". R19's admission records document R19's father resides in a city approximately 100 miles north of the facility.	F9999		