STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145275	A. BUILDING ______ B. WING ______	C **06/30/2005**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEKIN LIVING & REHAB CENTER	**2220 STATE STREET** **PEKIN, IL 61554**

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F9999	FINAL OBSERVATIONS	F9999		

STATE LICENSURE FINDINGS:

Section 300.1210 General Requirements for Nursing and Personal Care
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.

This REGULATION is not met as evidenced by:

Based on record review, interviews, and observation, the facility failed to do 15-minute checks as per care plan for 1 of 15 exit-seeking residents at the facility. This resulted in R1 leaving the building without staff's knowledge and walking approximately 1 mile before being found by a community member who called the facility.

Findings include:

According to the latest Physician Order Sheet, dated June 2005, R1 is an 76-year-old resident with diagnoses of Chronic Schizophrenia, Psychosis, Pacemaker, Parkinsons, Congestive Heart Failure, Chronic Aspiration Syndrome,

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among others. Minimum Data Set (MDS), dated 4/5/05, lists resident's skills for daily decision making as "moderately impaired." The MDS also indicates that the resident needs supervision for walking in the corridor. Latest Care Plan, dated through 7/5/05, outlines that resident is an elopement risk because of a history of attempts prior to admission and a "wandering tendency." Elopement Risk care plan also outlines that resident had attempted to exit facility twice 5/31/05, looking for his car. Plan of approach to exiting behavior lists "Supervise closely," "15-minute" checks, "re-direct wandering to a supervised area," "monitor exit alarms," "assess for " increased "restlessness...," "implement 1 : (on) 1 supervision if ... increased restlessness," among others.

Incident Report Form sent to the State Agency 6/17/05, 7:27 p.m., indicates that R1 was a " missing resident" 6/17/05, 5:50 p.m. Nurses Notes 6/17/05, 5:40 p.m. written by E3, Licensed Practical Nurse (LPN), indicate that she saw resident in the dining room at 5:40 p.m. At 5:50 p.m., E3 documented in the Nurses Notes that E 5, Activity Director, reported that a member of the community had called about R1's location. E5 then left to get the resident, per E3's documentation. When questioning E3 about the exact time of her seeing R1 in the dining room, she said, "It was approximately 5:40 p.m." During this interview, held 6/27/05, 2:03 p.m., she said that R1 "was done with the meal and was walking around the dining room." E3 also said that resident "has tried to elope before."

When interviewing E5, Activity Director, 6/27/05, 10:03 a.m., she said that she saw resident "

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wandering around the dining room approximately 20 minutes before the community member called ." She remembered that "at that time, he said he wanted a milkshake." E5 also said that "the only time the door alarm went off was between 5:30 and 5:45 p.m. when another resident opened the door to see how hot it was outside." E5 further said that at 5:50 p.m. a lady from the community called to inform her that she had encountered R1 on the corner of the street where community member lives. After E5 arrived at that location, R 1 told E5 that he had wanted to go to a local restaurant (named the restaurant) and that he had not known that this restaurant was closed.

Review of 6/17/05 second shift assignment sheet for Certified Nurses Assistants (CNA's) showed that E's 6, 7, 8 and 10 were the CNAs working on the wing where R1 is located. E6 provided a statement as part of the facility's investigation that he last saw resident at 5 p.m. According to the statement, R1 "was sitting at his table waiting for supper." During a telephone interview 6/27/05, 3:45 p.m., E6 outlined that upon R1's return to the facility, E6 did more than one hour of one-on-one with R1. During this time, R1 said to him he had wanted to go to Hopedale. (According to the map, this community is more than 15 miles away from facility.) When asked several times how he got out, he said "Someone came in; I went out." E7 was interviewed 6/27/05, 3:58 p.m. E7 said that she saw resident go down the hall where he lives shortly after 5 p.m. "He seemed agitated." This is the last time E7 saw resident before he left. During a 6/27/05, 2:18 p.m., interview, E8 said that she last saw resident "about 1 hour before the evening meal." E10 was briefly interviewed

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6/28/05, 2:03 p.m. She said that she "did not see anything."

Z1, member of community who called to let facility know R1's location, stated 6/27/05, 5:00 p.m. that she saw an "elderly gentleman" walking by her house in the early evening of 6/17/05. He was moving fast. Since she had never seen him in the neighborhood before, she was concerned. When asking resident where he was going, he said "downtown." She said "I don't know where downtown is. Do you?" R1 said "No." She then suggested that they go to Z1's patio to ask Z1's husband where downtown is. R1 readily came along. R1 told Z1 his name. When Z1 called the facility, they had no idea that R1 was missing.

When asking E9, Maintenance, how a resident could get out of the building without setting off the alarm, he said "Someone must have let him out or he followed someone." E9 verified that there was no Delayed Egress Lock System in place 6/17/05. The only system in place then required that someone punch in the code to deactivate it. This interview took place 6/27/05, 1:08 p.m. The 9 exit doors were checked 6/30/05, 11 a.m. All 9 doors were alarmed. Two of the doors had an additional alarm that could not be silenced by punching in the code. These alarms sounded until the doors were closed. Five doors gave a time span of 10 seconds or less until the alarm sounded after it was deactivated. The front door and the delivery door gave a 45-second time span until the alarm sounded after they were deactivated. When asking E1, Administrator, 6/30/05, approximately 11:30 a.m., whether anybody was monitoring these 2 doors during the time resident left, she said "no."

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Per observation, there are 2 routes to get to the intersection where R1 was found. It is not known which route R1 took. Driving the slightly longer way showed that resident would have had to cross 2 side streets while walking along a busy 4-lane thoroughfare. R1 would have to cross a total of 2 to 6 side streets in order to get to the location where he was found, depending on the route he took. Total distance of the longer route is approximately 1 mile, according to car odometer.

6/27/05, early afternoon, surveyor requested to see R1's 15-minute checks for June 17. Facility provided a sheet that was not filled out from 5 p.m. to 10 p.m. E's 6, 7 and 8 were the CNAs working second shift 6/17/05 on the wing where R1 resides. They were interviewed with respect to whose responsibility it was to fill out the 15-minute checks. (Per CNA assignment sheet for 6/17/05, E10 was on showers.) E6 said that since he was working on 2 other halls -- not the hall where R1 is located -- it was not his responsibility. This interview took place 6/27/05, 3:45 p.m. E7 was interviewed 6/27/05, 3:58 p.m. She said that it was the responsibility of "all CNAs on that wing." E8 was interviewed 6/27/05, 2:18 p.m. She said that she did not know whose responsibility it was to do the 15-minute checks around 5 p.m. and 6 p.m.

R2, an alert resident located in a room close to R1, was interviewed 6/27/05, 3:32 p.m. She said that R1 "always wants to get a milkshake" from a certain local restaurant and that one cannot go to that restaurant from where R1 was found. (This was verified per street map in the telephone

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F9999	Continued From page 12 directory.) R1 was observed walking on only one occasion, 6/27/05, 3:20 p.m. He walked around the nurses station close to his room and down 2 halls before sitting down in a chair in another resident's room. He was observed to have a wristband for the Delayed Egress Lock System on his wrist on several occasions, for example, 6/27/05, 12:07 p.m. When asking him at that time what the wristband was for, he said "getting out." He was interviewed at 12:07 p.m. and 1:18 p.m. On neither occasion did he know where he was at and what day it was. E11, Registered Nurse, had verified that resident was oriented to person, but not time and place, 6/27/05, 11:18 a.m.	F9999		