		AND HUMAN SERVICES				FORM	11/02/2005 APPROVED 0938-0391
	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	14E595		B. WIN	G			C 6/2005
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE D9 N W 9TH AVENUE		
MERCER	COUNTY NURSING	HOME			LEDO, IL 61231		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 324	Continued From pa	ige 7	F 3	24			
	transmitters for place basis. (8/29/05, 9	cement/expiration on a daily AM)					
	serviced nurse staf	eloped a procedure and in- f to check the transmitters for ly basis (per manufacturer (8/29/05, 9 AM)					
	serviced maintenar facility each day to	eloped a procedure and in- nce to check each door in make certain all (EMD) and working order. (8/29/05, 9					
	transmitters on whe	ewed the location of all eelchairs, making necessary d (per manufacturer (8/30/05, 3 PM)					
	supervision at front door is unlocked ur	gned staff to provide visual entrance during times that ntil such time that a back up alled to ensure resident (EMD) 50/05, 3 PM)					
	install keypad entry facility as a back up	acted (alarm company) to v system on front door of o system to (EMD). (8/30/05, erational by: (9/6/05)					
		ervice will be conducted to cy and procedure regarding 9/2/05)					
F9999	FINAL OBSERVAT	IONS	F99	99			
	STATE LICENSUR	E FINDINGS:					

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		I AND HUMAN SERVICES				FORM	11/02/2005 APPROVED 0938-0391	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		14E595	B. WI	NG _			C 6/2005	
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
MERCER	R COUNTY NURSING	HOME			309 N W 9TH AVENUE ALEDO, IL 61231			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE	
F9999	Continued From pa	ige 8	F99	999	9			
	Nursing and Person a) The facility must and services to atta practicable physica well-being of the re each resident's com plan of care. Adequ nursing care and po to each resident to personal care need b) General nursing minimum the follow a 24-hour, seven da 6) All necessar assure that the resi as free of accident nursing personnel s that each resident re and assistance to p Section 300.3100 C d) Doors and Wind 2) All exterior d signal that will alert the building. Any ex during certain period device for part-time hour a day supervis required.	provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with nprehensive assessment and uate and properly supervised ersonal care shall be provided meet the total nursing and Is of the resident. care shall include at a ring and shall be practiced on ay a week basis: y precautions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents.						

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		HAND HUMAN SERVICES				FORM	11/02/2005 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 14E595		(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WI	√G _			C 6/2005	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MERCER	R COUNTY NURSING	HOME			809 N W 9TH AVENUE ALEDO, IL 61231		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F9999	Continued From pa	ige 9	F9	999			
	observations, the fa 15 residents (R1) a . R1 left the facility staff. The facility fa Electronic Monitorin properly, failed to m front exit door, and direction for placem Findings include: E1, Administrator, v 9:30 AM regarding 18/05 at 5:50 AM in following informatio R1 exited the front	vs, record review, and acility failed to supervise 1 of assessed as an elopement risk of unnoticed and unattended by ailed to ensure EMD (ing Device) was functioning naintain visual control of the failed to follow manufacturer's nent of EMD device. was interviewed on 8/26/05 at an incident that occurred on 8/ hvolving R1. E1 provided the on: entrance of the facility in her as returned by a visitor who					
	found her stuck in L end of the parking L awareness based of Set) dated 6/7/05. had exited the build brought her back in self-propels her wh residents in the fact their wheel chairs of report dated 8/25/0 Public Health verified :40 AM stated, "We the morning of 8/18 restless. The last t quietly in her wheel station. E4 on 8/30	andscaping mulch near the lot. R1 has no safety on her MDS (Minimum Data Staff were not aware that R1 ding until after the visitor n. R1 is non-ambulatory but seelchair. There are 15 ility with EMD's attached to or person. Faxed Incident 15 sent to Illinois Department of					

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		I AND HUMAN SERVICES				FORM	11/02/2005 APPROVED 0938-0391	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	14E595		B. WI	NG _			C 6/2005	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
MERCER	COUNTY NURSING	HOME			309 N W 9TH AVENUE ALEDO, IL 61231			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE	
F9999	Continued From pa	ige 10	F99	999)			
	slippers the mornin	g of 8/18/05.						
	diagnosis of Senilir current Physicians' 05 under COGNITI DECISION-MAKIN Impaired." ELOPE dated 10/5/04 docu over facility to front Social Service Adm 97 documents that home a short distar admission. On 8/26/05 at 10 A with an EMD attach armrest. R1 was a confused. R1 was a confused. R1 was on 8/26/05 at 2:20 cross a road. R1 re again how she wou would do first. R1 r Nursing notes date document 9 incider go out front door ar asking to go home. are incidents when out the front door: 10/22/04: 3PM "Ag going out front doo assisted her back in yelling 'leave me al	female resident with a ty with Mental Confusion per Order Sheet. MDS dated 6/7/ VE SKILLS FOR DAILY G documents R1 as, "Severely MENT RISK ASSESSMENT ments, "At times (R1) moves door wanting to go home." hission Assessment dated 2/4/ R1 previously lived in her nee from facility before MR1 was in her wheelchair hed to the metal bar of her lert, hard of hearing, and questioned during interview PM regarding how she would eplied, "Walk." R1 was asked and cross a road and what she replied again, "Walk." d 10/17/04 through 8/27/05 hts involving R1 attempting to hd/or being agitated and The following nursing notes R1 actually attempted to go itation increased with resident r at 2:45 PM. Staff X 3 hside with difficulty. Resident one - let me go!' Biting, heels of w/c (wheelchair) from staff."						

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		AND HUMAN SERVICES				FORM	11/02/2005 APPROVED 0938-0391	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14E595	B. WI	\G		– 09/06/2005		
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
MERCER		HOME			809 N W 9TH AVENUE ALEDO, IL 61231			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE	
F9999	Continued From pa	ge 11	F99	999				
	doors, agitated and	ont lobby attempting to go out angry. Stating, 'I want to go alone and she needs me!'"						
	trying to go home n	nas been increasing restless, umerous times, redirect staril given IM (Intramuscular						
	6/22/05: 4:30 AM "F other side, trying to	Resident wandering over to go out front door."						
	stated the following He lives near the new walking his dog that he heard someone an animal at first ar was (R1) until he w was dark. He found her wheelchair stud	d R1) on 9/1/05 at 2:20 PM : ursing home and was out t morning around 6 AM when calling out. He thought it was nd couldn't make out that it alked closer. He stated that it d (R1) with the front wheels of ck in the mulch. He assisted (acility to the South nurses						
		Service Climatologist) on 9/1/ ed the sunrise on 8/18/05 at 6						
	outside where R1 w 190 feet (distance w front door to the en was roughly 40 feet Speed limit posted	AM E1 showed the site vas found by Z3. The site was valked off by E3) from the d of the parking lot. The site t from the street entrance. on street is 25 miles per hour. R1's Attending Physician) on 8/						
		stated that R1's level of						

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CENTER	TMENT OF HEALTH	TIPLE CONSTRUCTION	PRINTED: 11/02/200 FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY				
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDIN	NG	COMPLE	
		14E595	B. WI	NG _			C 6/2005
NAME OF P	ROVIDER OR SUPPLIER		4	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MERCER	COUNTY NURSING	HOME			309 N W 9TH AVENUE ALEDO, IL 61231		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F9999	Continued From pa	ge 12	F9	999)		
		ed." When questioned vould know how to cross a No, certainly not."					
	05 at 11:45 AM stat bad and sometimes other close family n whether or not R1 v Z2 replied, "No, she would get out there When asked if R1 v inside? Z2 replied, goes outside she ha that she is going ho						
	the following: The f EMD alarm system times a week with a This is confirmed by exit doors except th primary alarm syste sounds when a doo lights up a panel at which door has bee has to be re-set at t entrance doors are roughly 10 feet apa outer door has the door is equipped wi be turned on and of states that this alarn outer front exit door During tour with E3 tested all 3 exit door	n 8/30/05 at 10:40 AM stated facility has 3 exit doors with an . He checks the alarm 2-3 a transmitter tester at all doors. y log sheets. Z3 stated that all e front exit door have a em. The primary alarm system or is opened. This alarm also the nursing stations indicating en opened. The primary alarm he opened door. Front noted as double doors rt. Z3 stated that the front exit EMD alarm system. The inner th an alarm system that can if at the nurses station. E3 m is used at night when the ris locked. on 8/30/05 at 10:40 AM, E3 rs equipped with the EMD loading dock exit door did not					

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM OMB NO.	11/02/2005 APPROVED 0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		14E595	B. WI	NG _			5/2005
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MERCER		HOME			309 N W 9TH AVENUE ALEDO, IL 61231		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F9999	Continued From pa	ge 13	F9	999			
	alarm when E3 pas near the door. This the alarm was trigg E3 stated during too transmitters worn b On 8/30/05 at 10:50 Nurse) stated, "The	sed the Transmitter Tester was repeated 4 times before ered and the siren sounded. ur that he does not check the y residents. AM E9, RN (Registered front door is locked at 10 PM M, used to be 5 AM, time					
	The following inform facility's EMD operation	nation was obtained from the ation manual:					
	intended to work in overall patient secu reasonable operatir	rstem is designed and conjunction with facility's rity program, including ng policies and procedures. f cannot prevent the nts."					
	immediately. Be su	itter has expired, discard it ire to test all Transmitters on a ify proper operation."					
	attach the Transmit	r a patient in a wheelchair, ter to the seat or the back of tal on the chair can interfere r's signal."					
	basis by physically Transmitter Tester	also be tested on a regular entering an Exit Zone; the will detect whether or not a ing a signal, but cannot h of the signal."					
		M, E6, CNA, assisted in nent and expiration date of all					

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		AND HUMAN SERVICES				FORM	11/02/2005 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14E595	B. WI	NG _			C 6 /2005
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
MERCER	R COUNTY NURSING	HOME			309 N W 9TH AVENUE ALEDO, IL 61231		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F9999	Continued From pa	age 14	F9	999			
	-	rs. This concluded the					
	cross bars of whee 5 transmitters of portion of wheel ch 1 transmitter pl walking cane. 1 transmitter pl On 8/30/05 at 2 PM information: No one is specifica front door. Staff we resident transmitter placing the transmi according to the EM manual. E1 confirr 18/05 staff were no transmitters. E1 al front doors are unlo	were placed on the metal					

Facility ID: IL6006076