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	146035	A. BUILDING _____ B. WING _____	C 08/11/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH ADAMS HOME	**2259 EAST 1100TH STREET MENDON, IL 62351**

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F 324	Continued From page 7 5. 8/5/05-All twenty eight Elopement Risk residents reassessed by the Assistant Director of Nursing and another facility Registered Nurse. care plans were updated immediately for those who had changes.	F 324		
F9999	FINAL OBSERVATIONS 300.1210(a) 300.3100(d)(2) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial 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. 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. These requirements are not met as evidenced by : Based on observation, record review and interviews, the facility failed to effectively supervise 1 of 14 sampled residents identified to have wandering behaviors, (R1). Staff failed to	F9999		

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F9999	Continued From page 8 develop/implement additional means of supervision following an initial attempt by R1 to leave the facility. Staff failed to ensure 1 of 14 exit door alarms were functioning and failed to follow the facility policy for daily checks of door alarms. R1 left the facility unsupervised and without staff knowledge. Findings include: R1's medical record face sheet indicates that R1 was admitted to the facility on 7/11/05. Among his diagnoses listed on his History and Physical dated 7/6/05 are: Glioblastoma Multiforme (malignant brain tumor) with altered mental status, weakness and history of falling. R1's admission MDS (Minimum Data Set) dated 7/17/05 identifies R1 as moderately impaired for cognitive skills for daily decision making. The MDS also indicates that R1 has a behavior of wandering, is not easily redirected, and needs extensive assistance for locomotion off of the unit . It also documents that R1 has an unsteady gait. R1's careplan dated 7/11/05 indicates he has an unsteady gait and history of falls. Review of R1's Hospice careplan dated 7//13/05, includes: (electronic wrist alarm) per NH (nursing home), has dizziness and unsteady gait. R1's nurses notes for 7/14/05 at 1:15 am documents; "R1 activated door alarm and exited building. Attempted to keep door shut when staff pursued. Assisted back inside with assist of 2." R1's careplan dated 7/11/05 was reviewed. There was no documentation of the 7/14/05 exit seeking behavior until an entry dated 7/18/05.	F9999		

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F9999	Continued From page 9	F9999		

The 7/18/05 entry was made after R1 had eloped on 7/17/05. There were no interventions for this problem added to the care plan prior to 7/18/05.

The facility incident/investigation report for R1 dated 7/17/05 documents the following: At 7:30 am a visitor (Z2) reported to staff that he had just arrived and that he saw a man standing by the stop sign near the highway and he thought it was R1. A code was called and E7, LPN (Licensed Practical Nurse), went out the door and helped R 1 back inside. E4 and E6 both CNA's (Certified Nurse Aide) dressed R1 at 6:45 am. and reported that no door alarm was heard.

E7, LPN, was interviewed on 8/2/05 at 11:05 am regarding the above incident for R1. E7 stated that the staff were not aware that R1 was gone that morning. He stated that no alarms had sounded. He said, "I heard the code announced, 'resident outside', so I went right out and saw (R1) at the stop sign. (R1) was a little disoriented as I asked him if he was looking for the dining room. It took him some time and then he answered, 'I guess'. He had a look/expression of confusion like he had to really search for an answer." E7 was asked if he checked the door alarms to see if they were functioning. E7 stated, "No, I didn't." E7 was again interviewed on 8/3/05 at 11:15 am regarding if anyone checked the door alarms. E7 stated, "I did not and I don't know that anyone checked them."

During interview with E6,CNA, on 8/2/05 at 12:05 pm, E6 stated that she and E4 had last seen R1 at 6:30 am when they dressed him. E6 stated, "I didn't notice an alarm bracelet. The nurse said he had one on the day before but I don't remember

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F9999	Continued From page 10	F9999		

seeing one that morning." E6 was asked if R1 was confused. E6 replied, " 'Pretty sure he was confused. Most of the time he would just look at you and smile when you tried to talk to him.' We didn't know he was gone until we heard the Code called. We didn't hear any alarms sound. I don't think it was safe for him outside alone."

Z2 (visitor) was interviewed on 8/2/05 at 12:40 pm. Z2 stated, "He (R1) was standing on the left side of the stop sign by the highway. I thought I recognized him, so I went in and looked for him in his room. When I didn't find him, I went to the nurse to ask if he was in the dining room. She looked and he wasn't, so they went after him."

E5, CNA, was interviewed on 8/3/05 at 8:30 am. E5 stated, "I was also working on 7/14/05 when (R1) went out the doors. He did not have an (electronic monitoring alarm bracelet) on on the 14th. We asked that morning if they would get him one. I don't know if they ever did." E5 was asked if R1 had an alarm bracelet on on 7/17/05 when she last saw him. E5 replied, "Not sure if he had one on or not, didn't really pay attention to that."

On 8/3/05 at 8:50 am, E4, CNA, was asked if the staff were aware that R1 was out of the building. E4 stated, "First I knew of it was when a visitor (Z 2) came up to me. Last time we saw him was about 7:00 am." E4 was asked if R1 had an alarm bracelet on that morning when she and E6 dressed him. E4 stated, "No, he didn't."

Z1 (R1's spouse) was interviewed on 8/3/05 at 7: 23 pm. Z1 stated, "He was confused. You couldn't believe a word he said. He was falling a

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F9999	Continued From page 11 lot at home and I couldn't care for him there." On 8/5/05 at 9:05 am, E15, LPN, was interviewed regarding R1 wandering. E15 stated, "Oh yes, I took his wife on tour on admission and she told me he was wandering at home and then falling over things. She said that is why she had to bring him here. She said if she turned her back for one second he'd wander off. Yes, he had a history of wandering." In an interview with E2, DON (Director of Nursing), on 8/3/05 at 11:00 am., E2 was asked what action the facility took after R1 was returned to the facility on 7/17/05. E2 replied, "Well, the nurses notes say they looked him over and took him to breakfast. He (R1) didn't remember anything about it. I can't and could not find out the answers in the investigation. I can't find out who put the first alarm bracelet on him. I did not contact the visitors named in the investigation. We think he followed someone out. We didn't find out where or how he went out." E12, LPN, stated in interview on 8/5/05 that staff were not aware R1 was out until Z2 and E4 came to tell her. She stated, "When they said road, I called the code. 'Scared' cause he would not have been out there walking if he was capable of making decisions." The facility's system of supervision includes the use of general alarms on all exit doors. These alarms can be reset at the doors with the exception of the two doors in the Activity room designated at East Activity and West Activity doors. These two doors can only be manually reset at the Middle East nurses' station. A panel	F9999		

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F9999	Continued From page 12	F9999		

with buttons designated by door names was observed on the wall at the Middle East nurses' station.

During tour on 8/2/05 at 11:35 am, E3, ADON (Assistant Director of Nursing) was observed to open the East Activity door. No alarm sounded. E 3 stated, "It is off until we call the nurses' station and tell them to reset it. It is supposed to be on. The two doors in here can only be turned off at the (Middle East) nurses station." Staff were then observed to telephone the nurses' station to reset the door alarm. The Activity room is down a hall, past the dining room and lounge area. It can not be observed from the nurses' station. All other door alarms were observed to be functioning. At 11:50 am, during tour with E3 of the locked unit area, an exit door was observed. It opened into a fenced patio. A gate was observed within the fence. This gate was wide open. E3 was observed to close the gate at this time as she reported that it is not supposed to be open. She stated that they do not lock the gates.

The facility policy entitled Policy for Checking Door Alarms and last dated 11/04 was reviewed. The policy states: Maintenance will check the alarms on all exit door alarms on a daily basis. The current check list was reviewed and it notes the exit door alarm checks are done weekly. E11 (Maintenance) was interviewed on 8/ 3/05 at 11: 00 am and confirmed that the exit door alarms are checked weekly. E2, DON, stated during interview of 8/3/05 at 11:10 regarding the discrepancy, "I didn't update the policy to weekly ."

The facility is located in a rural community. There

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F9999	Continued From page 13 is a main highway with a speed limit of forty five miles per hour. On 8/3/05 between 1:00 pm and 1:05 pm ten vehicles were observed on this highway. There is also a blacktop road running in front of the facility which intersects with the main highway at the stop sign where R1 was reported to be found. On 8/2/05 between 12:03 pm and 12 :08 pm, six vehicles were observed to travel on this blacktop. There are bean fields and corn fields located in front of and to the North of the facility. There is a three to four foot deep ditch running along this side of the highway. The elopement risk picture log dated 7/15/05, identifies thirty residents. The 7/27/05 picture log indicates the facility had twenty eight residents identified as elopement risks during this survey.	F9999		