STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145142	A. BUILDING _____ B. WING _____	C 06/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ALMA NELSON MANOR	**550 SOUTH MULFORD AVENUE ROCKFORD, IL 61108**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.3100d)2) 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. b) General nursing care shall include at a 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 General Building Requirements 300.3100d) Doors and Windows 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 part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. These Regulations were not met based on	F9999		

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F9999	Continued From page 11 observation, record review, and interview wherein it was determined that the facility failed to supervise a newly admitted resident (R1) with a recent history (6/1/06) of wandering in the streets . R1 left the facility on 6/15/06 after she had been found removing the window screen in her room. R1's departure was unknown to the staff and R1 was found in the facility parking lot in an employee's car. The facility failed to have the front doors to the subacute area alarmed or have the doors under visual supervision on 6/15/06 from 5:00 a.m. to 8:00 a.m. Example: R1 is an 83 year old resident admitted on 6/13/06 with the diagnosis of Dementia, Hypertension, Diabetes, Hypothyroidism, and Breast Cancer per the 6/2006 Physician Order Sheet (POS). The Hospital History and Physical dated 6/8/06 documents R1's as being at risk for elopement due to being found wandering the streets at 5:00 a.m. on 6/1/06 by the police. The facility nurses' notes dated 6/13/06 contain documentation in R1 's admission note that she is alert but needs reorientation to place and time. Since admission on 6/13/06 through 6/22/06 the nurses' notes contain documentation that R1 is alert but confused. The facility's nurses' notes dated 6/15/06 at 5:00 a.m., document that R1 was found with her chair alarm off. R1 had removed the window screen in her room and attempted to leave the facility. There is no documentation contained in the nurses' notes about R1 leaving the facility. An attempt to interview R1 was made on 6/22/06	F9999		

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F9999	Continued From page 12	F9999		

at 10:00 a.m. R1 could not answer specific questions as to why she had left the facility or if she had left the facility. R1's response was "I don't want to talk about it." On 6/22/06 at 10:00 a .m. E3 (Certified Nursing Assistant) stated that R 1 was on a 1:1 supervision 24 hours a day 7 days a week due to her leaving the facility.

On 6/22/06 at 9:50 a.m., E1 (Administrator) stated that R1 was found in the facility Parking Lot in an employee's car. E1 could not be sure how long R1 had been missing but believes it was 10-15 minutes based on the last time R1 was seen. E1 stated that he was unaware of R1's risk for elopement prior to admission to the facility and that he had not read R1's Hospital History and Physical which documents that R1 had been found wandering in the streets by the police.

The facility's policy and procedure for Wanderers (Elopement) documents that the facility will identify potential wanderers if there is a history of wandering.

On 6/22/06 at 2:05 p.m. a tour of the facility was conducted with E1 and E5 (Maintenance Supervisor) and it was found that the front doors were not alarmed. E1 stated that the front doors to the subacute areas were never locked because these doors are not hooked to the fire alarm system. E1 also stated that there is only visual control of the front doors from 8:00 a.m. to 8:00 p.m. There are 2 sets of double doors in the dining room that lead to the outside that are not alarmed or under visual supervision. E1 confirmed that a resident could get to the parking lot or the street. It was also noted that in back of the subacute on the 400 wing area there was a

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F9999	Continued From page 13 corn field. On 6/27/06 E6 (Registered Nurse) stated that R1 had a diagnosis of Dementia and was not oriented to time and place, only self. E6 stated that she did not feel that R1 had survival skills and would get lost if out by herself. E6 also stated she would have expected R1 to be on a watch because of her recent history of wandering . On 6/27/06 Z5 (Physician's Office Nurse) stated that R1 had been seen by the Physician. The physician documented that she was demented and could not be left alone. Z5 stated that R1 would not know what to do if she was in a serious situation such as walking out in front of a car. (A)	F9999		