STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145136	A. BUILDING _____ B. WING _____	C 07/10/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN NURSING & REHAB CENTER	**304 MAPLE AVENUE AUBURN, IL 62615**

(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
F 324	Continued From page 3 , Director of Nursing and review of training and monitoring records the facility took the following actions to to remove the immediacy. 1) Placed R1 on 15 minute checks immediately and is still currently still on 15 minute checks. 2) Implemented door alarm checks at the beginning and end of each shift on 7/2/06. 3) Staff were inserviced on resident elopement policies on 7/2/06 and 7/3/06. 4) Door alarm drills were conducted on all shifts on 7/2/06 and 7/3/06. 5) An elopement risk book was developed with pictures of residents who have been assessed as elopement risks.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.1210 a) 300.3100 d)2) 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 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.	F9999		

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F9999	Continued From page 4 300.3100 General Building Requirements d) 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 requirements are not met as evidenced by : Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent the elopement of one resident (R1) of five residents who have been assessed at risk for elopement. R1 left the facility on 7/1/06 without the knowledge of staff. The findings include: R1 is an 84 year old woman. R1's record stated that she has a partial diagnosis of Alzheimer's disease with agitation and Psychotic Mood disorder. Her care plan dated 4/20/06 states she is an elopement risk because she wanders the building. It also states she is a fall risk due to a lack of safety awareness and that she will walk the hallways until she is exhausted. It also states she has long and short term memory loss, impaired communication and poor decision making skills. Based on interviews with E4, Licensed Practical	F9999		

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F9999	Continued From page 5 Nurse (LPN) on 7/6/06 and E6, Certified Nursing Assistant (CNA) on 7/10/06, R1 had been restless during the evening meal. She had gotten up from her table to walk the halls and was returned to her table several times. While E4 was passing medications she received a call from a police officer stating they had one of their residents at the city garage. E4 confirmed that R1 was missing and told the other staff. E6 said she was assisting a resident on the south hall when she heard that R1 had left the building and was down at the city garage. Since the south hallway door faced toward the city garage she went to the door and opened it and started walking towards it . E6 said when she opened the door she noticed that the alarm did not go off. She said the alarm had been turned off. E6 said she could not see R 1 at the garage and figured she was on the back side of the garage. E6 returned to the facility turned on the door alarm, and got into her car to go get R1. E6 said when she got there R1 was with the police officer and an Emergency Medical Technician (EMT). E6 signed a release and returned R1 to the facility. E6 said R1 was damp from perspiration and because she had been cooled down with towels by the EMT's. E4 said she did an assessment. No injuries were noted and R1's vital signs were normal. R1 was given fluids and a shower. E4 said that she had given R1 her medications shortly before the police called and didn't think that R1 was gone more than 10 minutes. E4 said she notified R1's doctor and family. Based on interviews with Z2, Police Officer, on 7/ 10/06 and Z1, EMT, on 7/6/06, someone had walked into the city hall/police station and said that there was a woman out by the ball field that	F9999		

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F9999	Continued From page 6	F9999		

seemed confused. Z2 said he drove down to the area of the ball fields and saw R1 in back of the city garage. Z2 said she had a shuffling gait and appeared hot. Z2 got her in his police car to cool her down and attempted to get some information from her. He could only get her first name. Z2 was concerned about her so he called Z1, EMT, to evaluate her at the city garage. Z1 said that R 1's vital signs were good but that R1 was perspiring. Z1 said he cooled her down with ice and cool towels. Z2 called the facility and asked if they were missing any residents. He said they were not aware of anyone missing. Z2 gave them R1's first name and they checked and realized they were missing R1.

An attempt was made on 7/6/06 to talk with R1. She would not respond to any questions. She would smile when asked some questions.

The area that R1 was found would require someone to walk approximately 180 to 200 yards from the facility. She was located by the police officer at 5:53 PM. The National Weather Service recorded a high temperature of 90 degrees Fahrenheit at 3:30 PM in Springfield, Illinois. The area around the facility is residential and traffic moves slow. There are ball fields nearby and railroad tracks.

(A)