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	145446	A. BUILDING _____ B. WING _____	C 07/21/2006

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MARIGOLD REHAB & HCC	**275 EAST CARL SANDBURG DRIVE GALESBURG, IL 61401**

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F 324	Continued From page 7 families will be notified by mail that the door alarm codes will be changed weekly and that the door alarm code should not be shared with residents. All EMS bracelets will be checked daily for fit and function on weekdays by the maintenance director and on the weekends by restorative aides. In the event that these staff are absent, the checking will be done by the charge nurse on duty. 7. The facility removed all EMS bracelets from metal walkers and wheelchairs on 7/19/06, and they were placed on the resident's person. 8. The facility conducted inservices on the placement of EMS devices according to manufacturer's recommendations and on the elopement policy and procedure, beginning on 7/20/06. All staff on duty 7/20/06 were inserviced at 1 PM. Staff not on duty will be called in for inservicing. All regularly scheduled staff that the facility was able to contact will be inserviced by midnight on 7/21/06. No other staff will be allowed to work until they have been inserviced.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210a) 300.1210b)6) 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	F9999		

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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. Restorative measures shall include at a minimum the following procedures:
b)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
d)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 interview, observation and record review, the facility failed to supervise one of 42 residents assessed as having elopement potential (R1). R1 left the facility unattended and unnoticed by staff. The facility failed to operate the resident electronic monitoring system (EMS) in accordance with the manufacturer's instructions and failed to have written policies and procedures for monitoring the system.

Findings include:

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A facility Incident Report dated 6/1/06 indicated that R1 eloped from the facility in her wheelchair on that evening and was observed wheeling herself down the sidewalk in front of the building at 7:30 PM. R1 was brought back into the building and found to have no injuries when assessed, according to the report. The report also indicated that R1 had last been seen by a staff nurse at 7:10 PM during a medication pass in the main hallway.

The written incident investigation completed by E 6 (Director of Nursing) indicated that R1 was noted out of the building that evening by E4 (Housekeeper), who brought her back into the building.

Interview with E4 on 7/14/06 at 11 AM indicated that on the evening of 6/1/06 at about 7:30 PM she was getting off work and driving out of the parking lot when she saw R1 in her wheelchair on the sidewalk in front of the veterinary clinic just east of the facility. E4 said that she got out of her car and was heading for R1, when R1 wheeled herself down the clinic's driveway and into the street in front of the clinic and the facility. E4 stated that R1 had reached the center turn lane in the street before she could get to her. E4 also said that cars had stopped and motorists were getting out to assist R1 at the time. E4 also stated that when she talked to R1 about going back to the building, R1 said that she was trying to get away and did not want to return, but did eventually permit E4 to push her back into the building. E4 stated that when she brought R1 through the front door, the EMS signal bracelet for R1 did not activate the system's alarm. E4

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also said that R1 was dressed appropriately that evening, and that the weather outside was nice and clear with a temperature of about 78 degrees Fahrenheit.

Observation of the outside area as described by E4 indicated that the driveway for the veterinary clinic next to the facility was approximately 150 paces from the front door of the facility. To reach that area, one has to go down the front sidewalk, traverse the facility front parking lot and the service drive leading to the back of the building, and then proceed east down a sidewalk along the street.

The facility's front set of doors is not visible from the nurses' stations, and is supervised by front office staff during regular business hours. The doors are equipped with audible alarms, and EMS monitors are present on both sides of the doors. EMS monitors are also located by internal doors leading from the Alzheimer Unit and the Pathways Unit sitting area. All 13 exit doors are equipped with an audible alarm system at the nurses' stations.

R1's Admission Form dated 7/10/06 indicated that the resident is 89 years old with a diagnosis of Dementia. R1's MDS (Minimum Data Set) assessment dated 4/4/06 indicated that R1's cognitive ability was coded as a "2" (moderately impaired). R1's latest care plan before the incident (dated 1/10/06) indicated that R1 had attempted to leave unsupervised shortly before that date, and that an EMS signal bracelet had been placed on her wheelchair for safety. The care plan stated that the bracelet was placed on the wheelchair because R1 was persistently

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working the bracelet off her wrist, and her ankles were too swollen.

Interview with R1 on 7/14/06 at 9:45 AM indicated that R1 was oriented to person, oriented to town but not the building, and not oriented to time. R1 did not remember trying to go out of the facility, and also did not remember safety precautions to take when crossing a street.

Interview with E1(Administrator) on 7/14/06 at 10: 45 AM indicated that facility staff never did determine why the EMS bracelet on R1's wheelchair did not activate the system on the evening on 6/1/06. E1 further stated that EMS bracelets are now checked for proper function every day instead of weekly, as before the incident. E1 said that there are no written facility policies for checking the EMS bracelets. Further interview with E1 on 7/20/06 at 10:30 AM indicated that the front door is supervised by staff in the front lobby from 8 AM until about 5 PM on the weekdays.

Interview with E2 (Acting Assistant Director of Nursing) on 7/14/06 at 11:25 AM confirmed that the EMS bracelet for R1 was located, at the time of the elopement, under the seat of her wheelchair where the lower frame crossbars meet.

Interview with E6 (Director of Nursing) on 7/18/06 at 9:25 AM indicated that her investigation discovered that no staff workers heard the main door alarm or an EMS alarm on the evening of 6/ 1/06 when R1 left unnoticed. E6 said that on the morning of 6/2/06, the main door alarm was found to work when all doors were opened, but

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F9999	Continued From page 12 that the EMS bracelet that was previously on R1 's wheelchair did not work when tested. E6 said that when she was notified on the evening of 6/1/ 06 of R1's elopement, she had nursing staff place a new EMS bracelet on R1's wheelchair. E6 stated that the only explanation for the failure of the main door alarm to sound when R1 left through the front door (since R1 was last seen at 7:10 PM that evening in the front area of the building) was that visitors exiting that door must have just overrode the door alarm with the keypad next to the door prior to R1's exit. E6 also did not know why the EMS bracelet failed that evening. Interview with E7 (Central Supply Clerk) on 7/19/ 06 at 10:15 AM indicated that she was the staff person responsible for checking the EMS bracelets with the EMS signal testing box prior to the incident of 6/1/06. E7 stated that the corporate policy, as of February 2006, was that the EMS bracelets were to be tested daily. E7 added that after her work time had been reduced to only 2 and 1/2 days per week in mid April 2006 , and also while she was on vacation much of May '06, the EMS bracelet checks were not done on a daily basis. E7 said that after the incident, the EMS checks are now done by E8 (Maintenance Supervisor) and E9 (Alzheimer Unit Coordinator) daily. The EMS bracelet test record for May '06 indicated that there were 41 residents monitored by the system. None of the records indicated that the bracelets were checked on a daily basis for any of the 41; and R1's bracelet was only checked for 3 days of the month, 5/30/06 being the last day before the 6/1/06 incident.	F9999		

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The EMS manufacturer's instruction sheet provided by E6 indicated the following warnings regarding the system: "Test each signaling device before using. Thereafter, test the device daily and record the results in the resident's records. ... Do not place the signaling device on or next to metal, such as wheelchair frames, jewelry, watches, etc. or allow it to come in contact with a door or associated hardware such as crash-bars, push bars, etc. Metal could interfere with the signal sent to the door modules ."

When E1, E6, and E8 were notified of these aforementioned warnings on 7/18/06 at approximately 11:00 AM, E8 immediately contacted the facility's provider for the EMS. Interview with E8 later at noon that day indicated that a staff person at the company told him that sometimes the signal devices will not work on wheelchairs because the metal interferes with the signal. E8 also said that the person told him that metal can cause the devices to "burn out" faster.

A daily facility roster check form of 42 residents monitored with the EMS and confirmed by interview with E6 at approximately 12:30 PM on 7/18/06 indicated that the EMS signal bracelets were being used on the wheelchairs of R2 and R 3. The list also indicated that the bracelets were on the metal walkers of R4 and R5.

The daily facility EMS check form logs were reviewed since the incident of 6/1/06. At least two forms were noted to have no dates, and no distinct forms were found, as confirmed by E6 on 7/19/06, for the following dates: 6/17, 6/18, 7/1, 7/

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F9999	Continued From page 14 2, 7/8 and 7/9/06. (A)	F9999		