STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145518	A. BUILDING _____ B. WING _____	C 01/06/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAR KA NURSING HOME	**201 SOUTH 10TH STREET MASCOUTAH, IL 62258**

(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 4 Please do not turn off alarms. Notify staff." 5. All at risk residents were re-assessed for elopement to assure that they were in the facility's elopement book. 6. A Quality Assurance Committee meeting was held on 12/26/05. It resulted in the following instructions: a. All departments are responsible for ensuring the safety of all residents. If nursing is in a position where the front door is needing to be observed by others, all other departments will be required to assist in monitoring the door and visitors. b. All department heads instructed that before the personalized door alarm is disarmed, a visual check needs to be done to assure no resident has exited. c. Staff informed that plans will be made for future events, which similarly have many visitors, for a staff member to be posted at the front door to assure resident safety.	F 324		
F9999	FINAL OBSERVATIONS STATE LICENSURE VIOLATIONS: 300.1210a) 300.1210b)6) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care	F9999		

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F9999	Continued From page 5 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. These REGULATIONS are not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow its plan of correction from the 05/16/05 survey by failing to provide adequate supervision to prevent the elopement of one resident (R1) of 16 residents assessed by the facility to be elopement risks, and by failing to respond to a door alarm and/or failing to keep the alram operating properly. This resulted in R1 eloping from the facility without staff knowledge on 12/25/05. E7 was off duty in her apartment next door when she observed R1 out of a window, at approximately 2:15 PM, walking towards the apartment complex by herself in the grass on facility property. No staff	F9999		

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F9999	Continued From page 6 on duty at the facility heard or responded to the front personalized door alarm as R1 eloped. This past non-compliance occurred starting 12/25 /05 and ending 12/26/05. Findings include: R1's Nurse's Notes dated 12/25/05 state, "2:20 PM. Nurse called on phone from [E7 -off duty Certified Nurses Aide - CNA] in nearby apartment . [E7] stated, 'I have one of your residents (R1). She is in front of my apartment...' I am trying to re -direct her back your way." These nurse's notes were written by on duty staff E4 (Licensed practical Nurse). Facility incident report dated 01/01/05 states, " Resident was escorted out of facility w/ visiting family. She was wearing pink coat, shirt, jeans, sock, T-shoes carrying a magazine. She walked to open lot next to facility still on nursing home campus. Notification from off duty staff alerting us resident out. resident was escorted safely back to facility no injuries noted." This report indicates the outdoor temperature was 55 degrees. On 01/04/06, at 12:30 PM and 1:40 PM respectively, E4 and E7 verified the incident as indicated above. E7 indicated R1 was walking fine and when she first got to R1 and asked "What are you doing?, R 1 stated , "I'm going home." E4 indicated that she and E10 (LPN) were working the nurses desk that day and both were called away from the desk to help with other	F9999		

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F9999	Continued From page 7	F9999		

residents on a resident wing. E7 indicated front area was left unmonitored at that point which is not supposed to be done. E4 indicated no alarms were going off when she returned to that area after picking up the phone call on a resident wing informing them of the elopement. There were many families visiting that day so they have surmised that R1 went out the front door with a visitor. They also surmise that a family member re-set the personalized alarm at the front door without notifying staff. E4 indicated there are visitors that have done that before.

Other staff (E9 - CNA, E6 - Housekeeper, E5 - Housekeeper, E10 - LPN) on duty at the time of the elopement, but in other areas of the building besides the central dining/activity room, indicated on 01/04/06, 01/05/06, and 01/06/06 that they did not hear any door alarms and were unaware of R1's elopement until they heard about it later. E10 also indicated that she has observed visitors re-set the personalized alarm.

R1's Cumulative Diagnosis Sheet indicates R1's has diagnoses which include: Dementia, Mental Status Changes, Delirium, Hallucinations, Decreased Balance, Seizure Disorder, Osteopetrosis, and History of Falls.

R1's Minimum Data Set - MDS (resident full assessment form) dated 10/26/05 indicates R1's Cognitive Skills for Daily Decision-making was at the Moderately Impaired level. The MDS also indicates R1 has short-term and long-term memory problems. It also indicates R1 exhibits daily wandering symptoms.

R1's Care Plan, dated 10/27/05, states that R1's "

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F9999	Continued From page 8 Problem #1 is at risk for elopement and makes attempts to leave the building out the front door throughout the week. The goal for this problem indicates R1 will not leave outside without staff awareness. One of the stated approaches for this goal includes to have a personal monitoring device "placed on resident." That monitoring device functions for the first set of doors at the front exit. On 01/05/06, R1 was interviewed. R1 did not remember exiting the building on her own. On 01/05/06 at 2:00 PM, Z3 (R1's Psychiatrist) stated that R1, like most of the residents he sees at this nursing home, does not have the cognitive ability to be safe on her own. Z3 stated, "If [R1] got further down the road she would have trouble getting back." The nursing home is located at the end of the residential length of a street which then continues on as a country road with wooded areas and farm land south of the facility. The grassy area to the north on the nursing home's property where R1 was sited by E7 and re-directed back towards the facility is not completely level and has some unevenness to it.	F9999		