STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145817	A. BUILDING ______ B. WING ______	C 04/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HOUSE OF CENTRALIA	**1000 MARTIN LUTHER KING DRIVE CENTRALIA, IL 62801**

(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 braclet to R1 upon return to the facility on 4-14-06. 4. Staff were inserviced on 4-14-06 regarding wanderguard elopement policy and procedures as well as 15 minute visual checks of all sunrise (locked) unit residents as well as all residents at risk for elopement. 5. The facility posted written memos regarding wander guard log book, visual check sheets, and door alarm log book on 4-14-06. 6. On 4-19-06 at 2:00pm, the facility decreased the 15 second delay time to 9 second delay on the C unit door, and applied an alarm to the exterior door in the kitchen.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)4) 300.1210b)6) 300.3100d)2) 300.7050b) 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. Restorative measures shall include at a minimum the	F9999		

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F9999	Continued From page 5	F9999		

following procedures:
b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
4) Personal care shall be provided 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

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.

Section 300.7050 Staffing
b) The unit shall have assigned, consistent staff. There shall be enough staff to meet the scheduled and unscheduled needs of each resident, as defined in the care plan, taking into account the purpose of the setting, the severity of the dementia, and the resident's physical abilities, behavior patterns, and social and medical needs.

Based on interview, observation, and record review the facility failed to provide adequate supervision to prevent the elopement of one resident (R1) out of a sample of six residents. R1

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F9999	Continued From page 6	F9999		

, who is cognitively impaired and moderately impaired for making daily decisions, left the facility on 4-14-06 without staff knowledge. This is due to the facility's failure to implement a system that would provide supervision for all confused residents, as evidenced by staff leaving the unit unattended, by allowing a 15 second delay of an alarm sounding to the C-unit door, and by failing to have the kitchen exit door alarmed or continuously supervised.

The findings include:

R1 is a 75 year old resident admitted to the facility on 4/3/04 with diagnoses which include Hypertension, COPD, Chronic Kidney Disease, Hypoxemia, Respiratory failure, CAD, Atrial Fibrillation, Advanced Alzheimer's, Hyperlipidemia, Depression, and Benign Prostatic Hypertrophy according to the physicians order sheet of 4-1-06. Based on surveyor's observation at 9:00 AM, on 4-19-06, and the cover of R1's chart, R1 resides on the locked C-unit at the facility. R1's annual assessment, dated 2-17-06, identifies R1 as having a problem with short and long term memory. Section 5 of the comprehensive assessment regarding the indicators of Delirium, shows that R1 has periods of altered perception or awareness of surroundings, episodes of disorganized speech, and restlessness. An interview with R1's physician (Z1) on 4-19-06 at 3:30 PM, confirms that R1 cannot be out of the facility unattended, and is unaware of hazards that the community may present. Based on an interview with R1 on 4-19-06, at 9:00 am, R1 mumbles nonsensical words and is unable to engage in a conversation.

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F9999	Continued From page 7	F9999		

In an interview on 4-20-06 at 6:45 AM, (Z2) police officer stated that no one called R1 in as missing on 4-14-06. Z2 was just driving in the area of 909 East Rexford street at 6:30 am on 4-14-06, when he saw R1 lying on his side in the street after an apparent fall. Z2 reported that R1 's hand was bloody, his pants were down around his ankles, and his diaper was filled with stool. R 1 had stool all over him and was unable to speak to Z2. Z2 reported that the dispatcher called the facility to see if they were missing a resident, and was told that the facility was not missing a resident. Z2 stated that R1 had an alarm on but the band did not have a name on it. Z2 reported having the dispatcher call the facility back to double check that they were not missing a resident. The staff at the facility then acknowledged that they had a resident missing by the name of R1. A review of the site where R 1 was found shows it to be approximately two blocks away from the facility in a residential area.

A review of the facility's investigation shows the facility was unable to determine how R1 left the facility unsupervised. In an interview on 4/19/06 at approximately 11:15 AM, E1, Registered Nurse, stated that she was the only nurse working at that time. E1 was not on the unit at the time of the elopement. E1 surmised that the only way R1 could get off the unit was to follow someone out the door next to the kitchen door, as it has a 15 second delay after the door is opened in which the alarm does not sound. A testing of this alarm confirmed on 4-19-06 at 1:00 PM, that surveyor could exit the door after closure of the door without the alarm sounding. Upon exiting the door, the kitchen door was noted to be open and the surveyor then went

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F9999	Continued From page 8 through the kitchen (approximately 20 feet) and outside through the unalarmed kitchen exit door. In an interview on 4-19-06 at 2:00 PM, E2, cook, stated that staff unlock the kitchen at 5:00 AM. In interviews with three certified nurses aides (E3 , E4, and E5) on 4/19/06 at 9:45, 9:55, and 10:15 respectively, all stated that they came in around 5 :45 AM on 4-14-06. E3, E4, and E5 all stated that the certified nurses aides (E6 and E7) assigned to the locked C unit were not on the floor, but in the break room with them between the time of 5:45 AM and 6:00 AM. In an interview on 4-19-06, at 11:30 AM, the licensed practical nurse investigating the elopement, E8, stated that she did hear a rumor that staff left the unit unattended. E8 then documented in a statement that she interviewed E6 and E7 who denied leaving the unit unattended. E8 assumed that R1 needed two alarm bracelets to prevent the elopement, and a cover for an electrical plug to the wander guard system on the C unit exit door. The statements in the investigation show that E1 reports last seeing R1 at 6:00 AM. Based on an observation on 4-19-06 at 2:00 PM, R1 had three skin tears to his left hand and a mild abrasion to his left knee. The investigation shows that R1 had been sent to the emergency room prior to return and received steri strips to the wound on his hand. (A)	F9999		